COLUMBIA LIBRARIES OFFSITE
HEALTH SCIENCES RESTRICTED
HR00412341

COLUMBIA UNIVERSITY
THE
LIBRARIES
IN THE CITY OF NEW YORK
HEALTH
SCIENCES
LIBRARY

JUL 2 8 1987

Digitized by the Internet Archive
in 2017 with funding from
National Endowment for the Humanities (NEH)

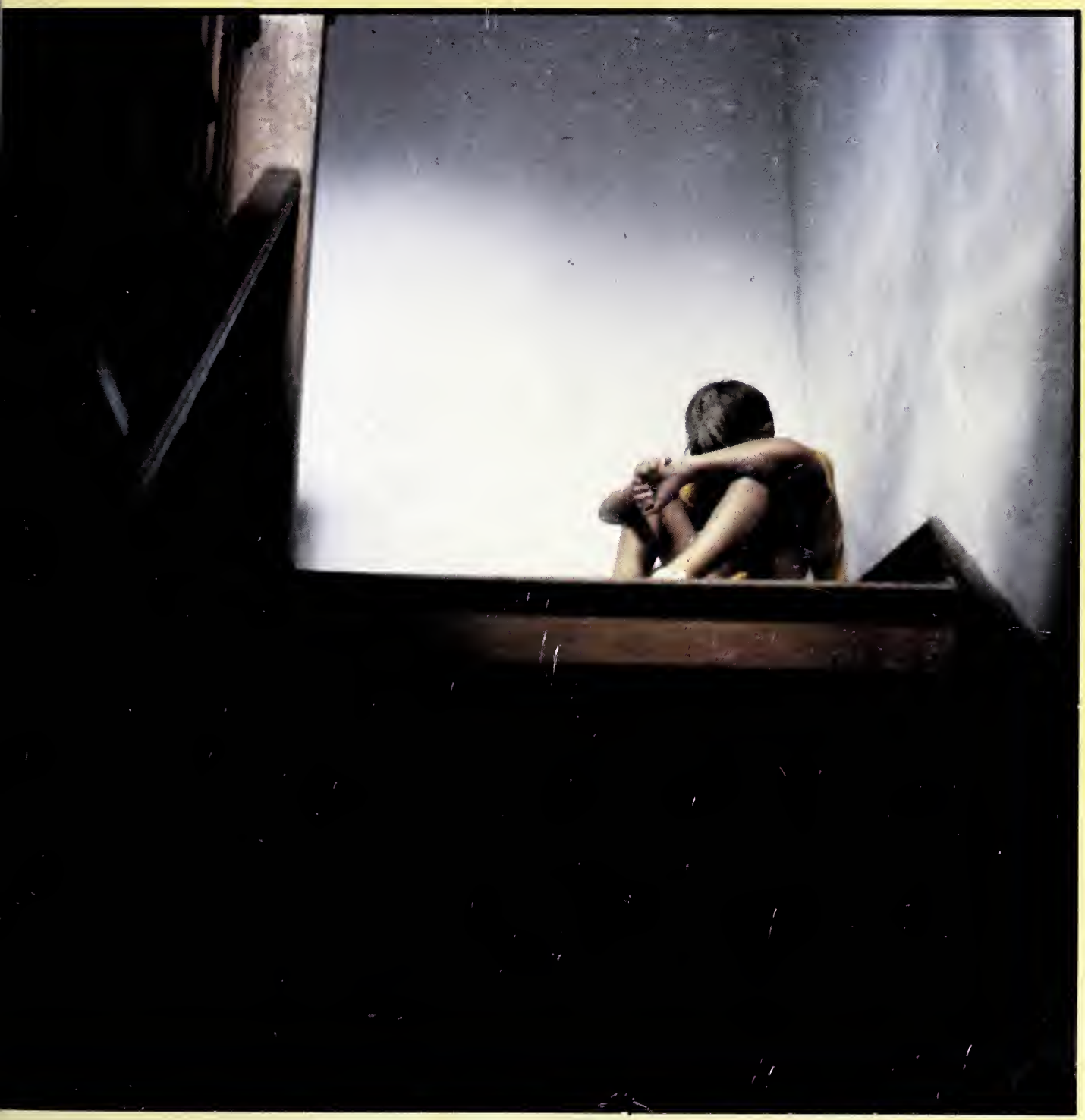
https://archive.org/details/journaloffflorida00flor_0

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. July 1985 Vol. 72, No. 7

COLUMBIA UNIVERSITY
JUL 25
MEDICAL SCIENCES
LIBRARY

Need NII
B.O. 12/18/86 OP

SPECIAL ISSUE ON CHILD ABUSE



UP-TO-DATE!

FPIR Systems mean Quality Service.



The new management of Florida Physicians Insurance Reciprocal stresses quality control of the Underwriting , Accounting and Claims Processing functions. The new management team is experienced in operating medical professional liability insurance companies and understands the unique needs of the physician-owned company. FPIR is the only company sponsored by the Florida Medical Association and it stands ready to offer its experienced team for Florida's physicians.

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

July 1985 "Doctors Helping Doctors" Vol. 2 — No. 3

Georgia IP Program Publishes Data on First Decade Experience

Family physicians and general practitioners comprise the largest single group entering treatment in the first decade of the Medical Association of Georgia's Impaired Physicians Program.

FPs and GPs accounted for 193 or 28.6 per cent of the 675 admissions from the beginning of the program in 1974 to the end of July 1984. This is more than double their representation in the total physician population (12.5 per cent), according to Karl V. Gallegos, M.D., and Merrill Norton, R.Ph., in an article published in the November 1984 issue of *Journal of the Medical Association of Georgia.*

Internists had 85 admissions or 12.6 per cent of the total, but this is somewhat below their proportion of the total physician population (15.5 per cent). Anesthesiologists made up 10.4 per cent of the patient load but account for only 3.5 per cent of the total population.

"There appear to be 'vulnerable' specialties that may have an increased risk for chemical dependence: anesthesia, family or general practice, and emergency medicine," the authors wrote. "Drug availability, job stress, and boredom are believed by the authors to be aspects of these specialties that make individuals within their ranks at risk for chemical dependence."

The article listed the 10 specialties most commonly seen in the Georgia program and compared their percentage part of the total patient load with their percentage of the total physician population as determined by the American Medical Association:

	IPP Population		AMA Population
	Frequency	Pct.	Per Cent
Family Practice or General Practice	193	28.6	12.5
Internal Medicine	85	12.6	15.5
Anesthesia	70	10.4	3.5
General Surgery	45	6.7	7.1
Psychiatry	42	6.2	5.8
Ob-Gyn	39	5.8	5.6
Emergency	24	3.6	1.6
Pediatrics	22	3.3	6.1
Orthopedics	21	3.1	3.0
Radiology	19	2.8	2.0
Other	115	17.0	37.3

By sex, the patient population broke down to 650 male and 25 females. Women physicians entering the Georgia program comprised a much smaller percentage than their representation in the total physician population (3.7 per cent vs. 12.2 per cent).

Veterinarians Donate $6,000 to IP Program

The Florida Veterinary Medical Association (FVMA) has made a donation of $6,000 to the FMA-FMF Impaired Physicians Program.

William F. Casler, D.V.M., J.D., of St. Petersburg Beach, presented the check to IPP Medical Director Roger A. Goetz, M.D., during an Intervention Workshop in Jacksonville on May 26.

Dr. Goetz and his wife, Kay, presented the program for the half-day session, which was attended by about 30 veterinarians.

The FVMA has been the health professional organization most supportive of the IPP through its Executive Vice President, H. Larry Gore, D.V.M., and others. Several impaired veterinarians have been treated and rehabilitated through the IPP.

All States Now Have Impairment Programs

All state medical associations now have some sort of a program to deal with the problem of the impaired physician.

AMA's Board of Trustees reported to the AMA House of Delegates in Chicago last month that the programs differ greatly from state to state. Some programs are low-key, keep no records and provide help only if the physician wants it.

Other programs have a more assertive approach. They investigate and advise the physician he needs treatment. If he does not agree to enter treatment and remain in therapy until discharged, the impaired physician risks having his case reported to the licensing board.

Most state association programs fall somewhere between these two extremes, the AMA report said.

The Florida IPP offers more complete efforts to assist the sick physician before his addiction begins to cause great troubles in the lives of others as well as his own. By agreeing to treatment within the IPP, the troubled physician gains an advocate before the Florida Board of Medical Examiners.

Want to Help a Troubled Friend? Help Is Just a Phone Call Away

(Editor's Note: Following is the first of a series of brief articles describing various facets of the Impaired Physicians Program prepared by Medical Director Roger A. Goetz, M.D.)

A telephone call to the Florida Medical Foundation's Impaired Physicians Program is all that is needed to begin a process designed to help the afflicted physician, his professional associates, his hospital, the medical consumer and the physician's family.

Early notification is important. All too often calls are received too late, after many difficulties have occurred and when the medical associates of the impaired physician are already in some form of jeopardy.

The call is received by the confidential staff of the IPP. This staff is separate from that of the Florida Medical Association/Foundation. It has a separate office and telephone system. The caller need not identify himself to report an impaired physician or to receive information and guidance. The program protects both the caller and the troubled physician.

The call is transferred to the author as Medical Director of the IPP or, in his absence, to the physician on call for further information.

A case file is begun and the situation is evaluated with the assistance of local individuals experienced in impairment and other confidential sources, retaining the troubled physician's anonymity.

After adequate information is obtained and verified, action is taken. This usually consists of counselling and exchange of information with medical associates to help them and the troubled physician. An intervention may then be necessary, and treatment arranged.

NEW IP NUMBER

Physicians wishing to refer colleagues to the FMA-FMF Impaired Physicians Program should call:

(904) 354-3397

Drug Education Course Planned

A work group consisting of representatives of the FMA Council on Scientific Activities and Committee on Substance Abuse has begun designing a CME curriculum to help physicians sharpen up their drug prescribing habits.

They hope to offer the program for the first time in the spring of 1986. Topics will include non-chemical approaches to pain and stress management, the disease concept of addiction, and the problem of the patient who is taking multiple drugs ordered by two or more prescribers.

"Caduceus" Prints Still Available

Looking for a worthy cause to help?

Then consider a donation to the Florida Medical Foundation's Impaired Physicians Treatment Loan Fund. Donations are tax deductible.

In return for a gift of $300 or more, the Foundation will give the donor an authenticated and numbered reproduction of "CADUCEUS", the well-known painting by the late Jacksonville artist Lee Adams.

Adams created "CADUCEUS" especially for the old FMA Headquarters Building in Jacksonville almost 30 years ago. The original still hangs in FMA's present office.

Prints are shipped unframed in a protective mailing tube. They make excellent gifts for close relatives and friends on special occasions such as medical school or college graduation, anniversaries and birthdays.

Checks made payable to "Florida Medical Foundation" and designated for the "Impaired Physician Loan Fund" should be mailed to the Foundation, Attn: Mr. Edward D. Hagan, P.O. Box 2411, Jacksonville, FL 32203.

Dr. Selander Renamed To Committee Chair

FMA President Luis Perez, M.D., has appointed Jacksonville family physician Guy T. Selander, M.D., to his sixth consecutive term as Chairman of the Committee on Impaired Physicians.

Other members of the Committee for 1985-86, all reappointed, include: Arvey I. Rogers, M.D., Miami; John F. Mason, Jr., M.D., Panama City; John M. Butcher, M.D., Sarasota; Mrs. B. David (Edie) Epstein, Key Biscayne; Hector Mendez, M.D., Orlando; Nelita R. Ano, M.D., South Daytona; Harold L. Ishler, Jr., M.D., Clearwater; Laurin G. Smith, M.D., Vero Beach; and Dolores A. Morgan, M.D., Miami Beach.



The Fifth Annual Section on Chemical Dependency at the FMA Annual Meeting in May featured a panel discussion on "Medico-legal Implications of Physician Substance Abuse," which was moderated by E. Joan Barice, M.D., of Palm Beach Gardens (standing). Panelists included (left to right): Roger A. Goetz, M.D., IPP Medical Director; Dolores A. Morgan, M.D., Miami Beach; and Richard J. Feinstein, M.D., Miami, a member of the Florida Board of Medical Examiners.

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

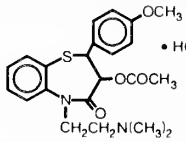
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CAROIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CAROIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.



The appearance of these tablets is a registered trademark of Wyeth Laboratories.

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

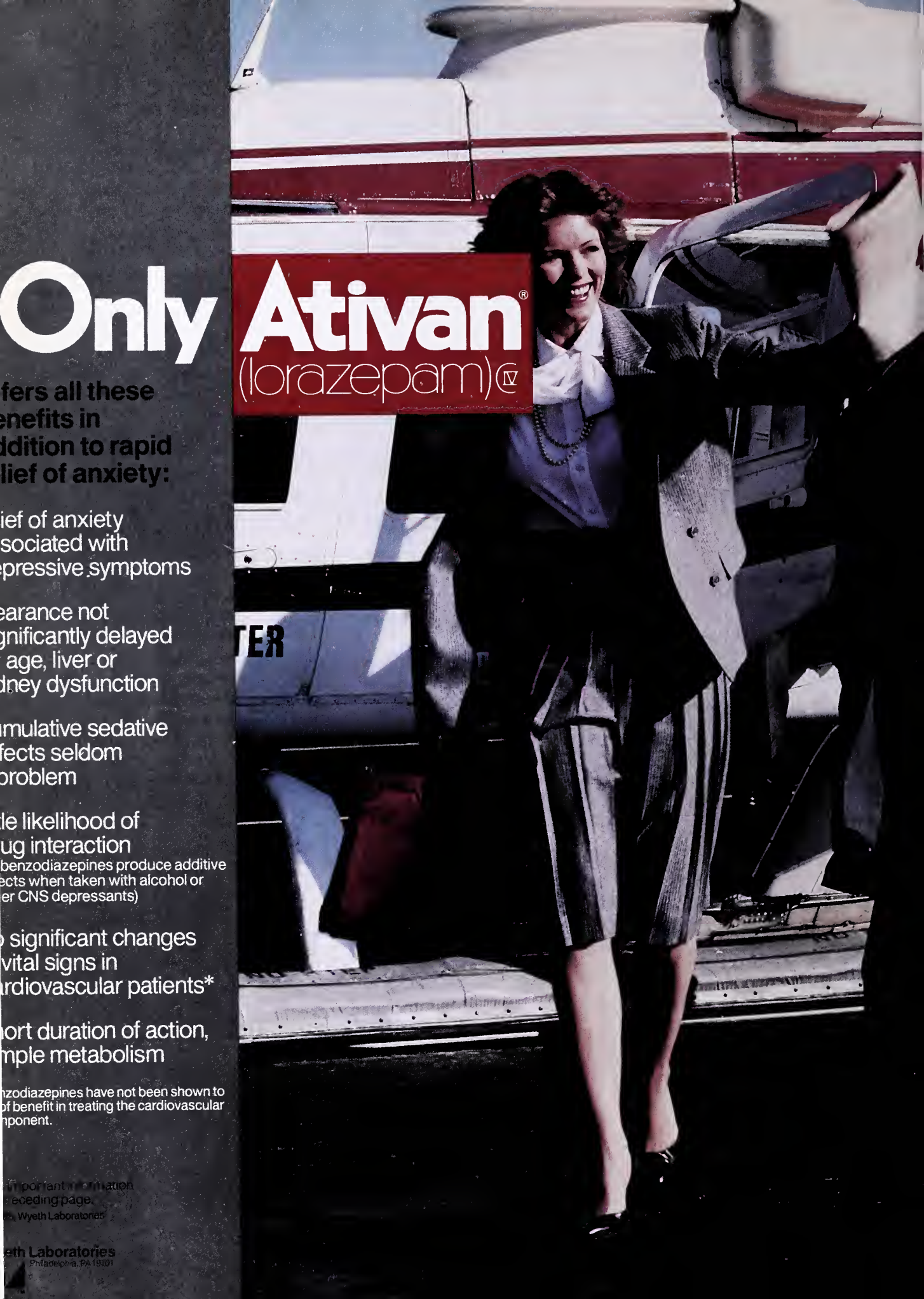
Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (lorazepam) **for Anxiety**

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101


Only
Ativan®
(lorazepam)C IV
fers all these
enefits in
ddition to rapid
lief of anxiety:
ief of anxiety
sociated with
epressive symptoms
earance not
gnificantly delayed
age, liver or
dney dysfunction
mulative sedative
fects seldom
problem
le likelihood of
ug interaction
benzodiazepines produce additive
ects when taken with alcohol or
er CNS depressants)
significant changes
vital signs in
rdiovascular patients*
ort duration of action,
mple metabolism
nzodiazepines have not been shown to
of benefit in treating the cardiovascular
nponent.
portant information
eceding page.
Wyeth Laboratories
eth Laboratories
Philadelphia, PA 19101



No One Is More Ill Than A Patient Who Tries To Hide His Illness From His Doctor.

You know it's not your everyday patient problem. Alcoholism is far different from most other diseases. Patients try to hide it from you. They resist treatment. They deny they have the disease at all.

Such a complex physical and emotional problem usually requires extensive evaluation. And intervention counseling is frequently needed.

If you are a specialist in addiction treatment, you're equipped to deal with these problems. If not, consider Brookwood Recovery Center as your specialist and partner in the treatment of alcoholism and drug abuse. We're a specialized facility staffed to serve both your patient and patient's family. Our nationally recognized treatment programs have given us one of the best recovery rates in the country. And once recovered, your patients and their families return to being the kind of patients that let you help them once again.

For further information on how a Brookwood Recovery Center can help you effectively treat this problem, call our treatment center in Orlando (305/841-7071) or Tampa (813/884-1904 or, toll-free in Pinellas County, 813/447-4806) anytime, day or night.

BROOKWOOD RECOVERY CENTERS

A health care service of American Medical International

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC

JULY 1985 Vol. 72, No. 7

CONTENTS

SCIENTIFIC ARTICLES

J. M. Whitworth, M.D.	**495**	Child abuse: old problem, new perspectives
Alison H. Watkins, A.R.N.P. Richard J. Gagan, Ph.D. and J. Michael Cupoli, M.D.	**497**	Child abuse by burning
Barbara A. Eagan, M.A., Susan Whelan-Williams, William G. Brooks Jr., M.D.	**503**	The abuse of infants by manual shaking: medical, social and legal issues
James J. Arnone, A.C.S.W., and L. R. Leviton, M.D.	**508**	The incestuous family: profile and treatment plan
Samuel H. Moorer Jr., M.D.	**511**	Spasmus nutans occuring with child abuse/ neglect

SPECIAL ARTICLES

David P. Adams	**517**	General practice in rural Florida: case study of an anomaly
Juan V. Fayos, M.D.	**522**	Academic radiology: can it survive?

EDITORIALS

R. G. Lacsamana, M.D.	**489**	Medicine under the gun
Richard J. Feinstein, M.D.	**491**	Malpractice relief: is it coming?

COVER

This months cover of *The Journal* depicts the theme of this Special Issue on Child Abuse. The photograph was reprinted with permission from The Childrens's Medical Services.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1985 by Florida Medical Association, Inc.

DEPARTMENTS

Luis M. Perez, M.D.	**485**	President's Page The Board of Governors: an open forum
Jacques R. Caldwell, M.D.	**527**	Medical Economics The Health Maintenance Organization as a cost containment instrument: logic or illusion?
	533	Notes and News
William B. Deal, M.D.	**535**	Dean's Message Brother against brother?
	535	Encores!
	539	Correspondence
	541	Scam of the Month
	541	Correction
	545	Book Review
Carolyn C. Spore	**549**	FMA Auxiliary Medical malpractice — a study in evolutionary politics
	552	Meetings
	554	Classified Advertising
	558	Index to Advertisers
	558	FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
Frank H. Farmer Jr., M.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Philip Altus, M.D.
Fuad S. Ashkar, M.D.
Thomas D. Bartley, M.D.
Pierre J. Bouis Jr., M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Mrs. Dale R. Charneco
Charles Craig, M.D.
R. Jay Cummings Jr., M.D.
Raul V. deVelasco, M.D.
Pablo Enriquez, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
James T. Howell, M.D.
Harold L. Ishler Jr., M.D.
Nicholas H. Kalvin, M.D.
Karl J. Kramer, M.D.
Jeffrey Lang, M.D.
Michael S. Levine, M.D.
Richard F. Lockey, M.D.
Mr. Dale Matza
Philander D. Morgan, M.D.
George Morris, M.D.
Richard S. Panush, M.D.
R.A. Penalver, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
Arvey I. Rogers, M.D.
William J. Romanos, M.D.
Hubert L. Rosomoff, M.D.
Lees M. Schadel, M.D.
Frederick W. Schert, M.D.
Jack J. Schneider, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Roberto A. Sosa, M.D.
Michael E. Steier, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victoria, M.D.
George Watkins, M.D.
Charles D. Williams, M.D.
Frederic C. Wurtzel, M.D.

The AMA puts current information at your fingertips



The first nationwide medical information network brings a new dimension to the way in which physicians can keep abreast of the latest knowledge in their profession. Through the use of a low-cost computer terminal you can have access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips . . .

DATA BASES:

Drug Information

- Contains up-to-date information on the clinical use of drugs
- More than 1,200 individual drug preparations marketed over some 5,000 trade names
- Can identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions

Excerpta Medica Physicians Information Retrieval and Educational Service

- Index to clinical literature — aids subscribers in locating recent articles and peer reviewed papers that have appeared in more than 300 medical journals worldwide
- Periodicals selected for inclusion in this service cover over 78 specialties and subspecialties
- Helps physicians locate relevant articles quickly and to stay abreast of new developments — saves time

Continuing Medical Education

- Developed by Massachusetts General Hospital in conjunction with the Harvard Medical School
- Allows physicians to earn Category I ACCME credits
- Provides individualized self-paced learning experiences based upon computer simulated patient cases
- Physicians will interact with teaching situation through four predetermined styles: multiple choice, vocabulary, fee text, and tutorial
- Provides confidential means of self-assessment for practicing physicians
- Solutions to problems presented in each teaching scenario can be reviewed and evaluated instantly

Socio-Economic Bibliographic Information

- Guide for locating current articles on the nonclinical aspect of health care
- Includes 4,200 citations from more than 700 health care publications
- Subject areas include economics, education, ethics, international relations, legislation, medical practice, political science, psychology, public health, sociology and statistics
- Convenient ordering of full text reprint of articles directly from the AMA through MED/MAIL

Medical Procedural Coding and Nomenclature

- Provides uniform coding and nomenclature system for reporting medical services and procedures performed by physicians
- Contains 6,000 descriptions of procedures

Disease Information

- Contains descriptions of diseases, disorders and conditions

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION,
PLEASE CONTACT THE
FLORIDA MEDICAL ASSOCIATION, INC.
JACKSONVILLE, FLORIDA
TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION INC. 1874

Board of Governors: an open forum



The Board of Governors Meeting of the Florida Medical Association, Inc., June 28-29, was a fine example of unity in action.

The usual meeting between the Executive Committee and the Chairmen of the various councils and committees, as well as the Board itself, was enhanced by the attendance of several county society medical presidents and executives. The dynamic participation of all the members present was vibrant and enlightening. All were heard on every issue they wanted to address, and the positive and well thought out decisions of the Board were attuned to the opinions expressed by all.

It was an excellent example of an open forum of a democratic environment at work for the common good of the Association as a whole, and for the people of Florida whose health and well-being are our primary responsibilities.

Short and long-term programs geared to present and future issues ranging from public relations to the political forum were decided in general terms as the goals of our Association.

The decisions made at this meeting will be published in a future edition of *The Journal*. I plead with you to carefully and thoughtfully consider every issue so the proper implications of each one are understood. Your comments and positive suggestions are welcome on each one of our programs. I emphasize that these programs deal with our problems. You must all agree that we have leaders in our midst whose clear thinking is based on moral and ethical principles, and who express their thoughts in an intelligent and logical manner.

Members of your Board of Governors with years of experience in different fields and endeavors have the common goals and principles of medicine which we all understand. The Board of Governors made the final decision on all the issues in a very positive manner, giving birth to a specific direction for the Association's future, a direction in which we want to function in order to confront the problems that the State and Federal Government present to us face to face. We must find areas of understanding, as well as areas of discrepancy, and work on them united as one body. We derive strength from each other within our family of medicine and only we are the experts in this field.

Through his life, the practicing physician sees patients everyday and realizes the shortcomings of government sponsored health programs based on economics rather than quality of care. The Florida Medical Association and the American Medical Association on the national level are also aware of such problems and together, along with the county medical societies, form the strongest federation to fight the government interference that fails to take into consideration the health and well-being of our population. Our individual physicians and medical societies are the full guardians of the health of the nation.

As physicians, we must unite. We must encourage our individual members at the local medical society level to participate in the deliberations and give us their input. We must strengthen our channels of communication so that each concerned member communicates with the Board of Governors, county society presidents, and representatives. With participation by individual members and strengthened communications, we can work together to attain our goals and accomplish what has never been accomplished before. Different factions may choose to reject this new united direction and concentrate on isolated issues. They are blind to the overall picture in the state and will produce no positive results. Our strength is our unity.

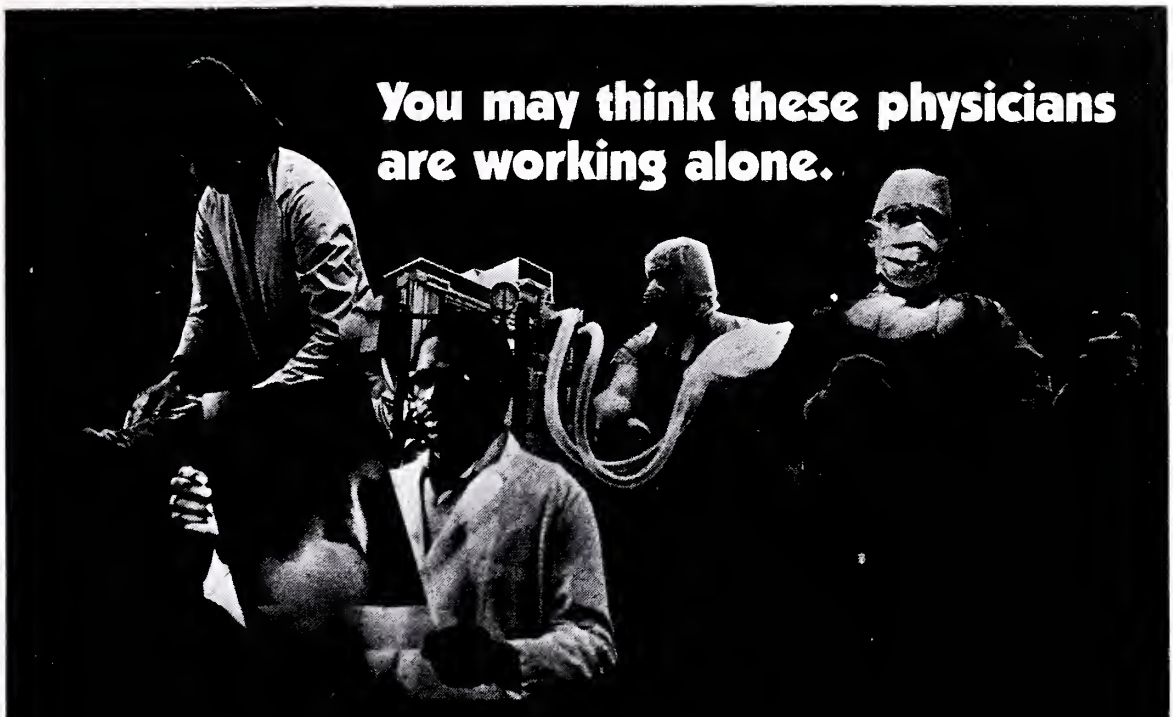




A Kiss Can Save A Life

When you kiss your child, you give and receive love. But your kiss could also be a test for cystic fibrosis, an inherited respiratory and digestive disease. An excessively salty taste to the skin is one symptom of cystic fibrosis. Call your doctor or local Cystic Fibrosis Foundation Chapter for more information. Early diagnosis and treatment can be the key to a better quality of life for CF children.

Meantime, kiss your baby. It's a good idea, anyway.



You may think these physicians are working alone.

But they really have a team behind them.

These physicians spend most of their day working independently in a one-to-one doctor-patient relationship. And chances are that as a physician, you do too.

But even though you can't see it, there's a strong team supporting and protecting the medical profession, affecting your practice while you see patients, research new drugs or perform surgery. That team consists of *your medical societies.*

The American Medical Association and your state and county medical societies believe in the value of teamwork: that only by working together can we, in the face of an increasingly complex professional environment, protect your right to make responsible decisions on how to practice medicine.

We also believe that all medical societies — county, state, and national — have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

Tasks such as keeping government regulations from interfering with your practice by representing your interests at local and national levels. And challenging regulatory measures that threaten you and your patients' interests by mounting legal campaigns to defend your rights — up to the Supreme Court if necessary.

Why do we believe that *teamwork* means so much to *all* physicians — even those who work "alone"?

Because . . . IT WORKS.

Join Your Medical Societies Today.

For more information, contact your state or county medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

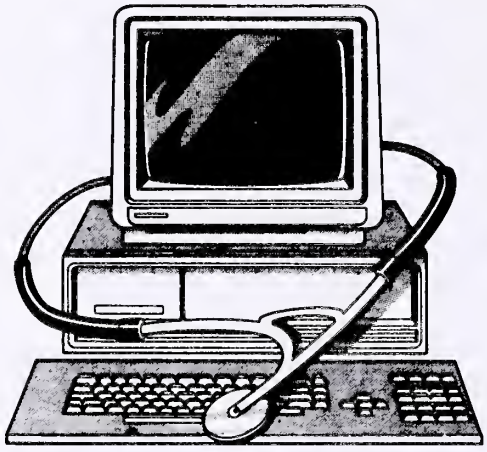
City _____ State _____ Zip _____

County _____

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

()

Specialty Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Medicine under the gun

The new climate where health care is being increasingly shaped by a welter of political and economic forces is eroding the traditional medical image and redefining the course of medicine. Medicine is now looked upon as just another type of business, while physicians are perceived as new entrepreneurs who are shedding their traditional white gowns for the gray flannel suits of Wall Street. This shift in focus is dramatically bringing about a wave of changes, some of them revolutionary, with no indication that they will grind to a halt soon. While the impact of these changes is still being debated, the consensus among physicians is that medicine had seen its better days.

The much-ballyhooed high cost of medical care has been the big stimulus behind all these changes. From a period not too long ago when there was a virtual bonanza for everybody, we have entered an era where the pie is getting smaller and smaller. The picture becomes even more muddled with an expected overabundance of physicians competing for a shrinking market. Only five years ago, nobody could have imagined that these numbing developments would ever come to pass. Medicine, after all, has never been perceived as a business, and traditionally has been immune from the pernicious influence of political and economic forces.

The increasing dominance of political and economic imperatives in medical care places the medical profession and physicians under a glaring spotlight. Although the escalation of medical costs the past several years can be attributed to a number of reasons — inflation, medical technology, an aging population, and rising demands for medical care, among other things — physicians are visible targets and convenient scapegoats in the whole scheme of things. Medicine may have brought forth miracle drugs and exciting technological advances; at the same time, almost everybody knows that physicians have benefited handsomely from the situation. The six-figure income of most physicians is common public knowledge. So is their image of affluence. Is it any wonder then that the government has found it easy to sidestep them by onerously imposing a new order of things? Physicians are certainly not getting much sympathy from the public, which perceives the problem as just another pocketbook issue for doctors. Beset by mounting government regulations on one hand, and pushed on the other by a sagging public image, physicians have found themselves as sacrificial lambs on the altar of cost containment.

It is a deep predicament for physicians to be in. To believe, however, that physicians have put themselves into a deep hole and have nobody but themselves to blame, as a lot of people think, is to miss the point. Most physicians are honest, hard-working, and motivated by a genuine desire to help their patients. There are physicians who obviously practice their profession for monetary motives and who have made a bundle by their profiteering, but they constitute a tiny minority. The perceived excesses of the medical system cannot by any stretch of imagination be laid on the doors of physicians. The advent of better patient care and modern scientific advances made medical care more expensive, but that should have been expected. Americans are now living longer and healthier lives, a number of diseases have been eradicated, and many disabling ailments can now be kept under control. Medical progress, however, has become a cruel paradox, and physicians are paying dearly for it.

The current situation where physicians find themselves being dislocated from their traditional roles as decision-makers in medicine by the govern-

ment, corporations, insurance companies, and other third parties will have deep repercussions on the future of medicine. In addition, the political and economic forces now at play may lead to the dismantling of what is indisputably the best system of medical care ever devised anywhere, with the increasing specter that socialized medicine may not be far behind.

Most physicians entered the profession of medicine imbued with humanitarian motives, but a big number of them are getting cynical about what is going on. How can physicians maintain the revered ideals of their profession and instill them to younger generations when dollars and cents are becoming the central focus of the physician-patient relationship? The current public perception of the medical profession confirms the shifting moods of Americans about their doctors. In a recent research conducted for the AMA, 54% of respondents felt that doctors do not care as much about people as they used to; 44% believed that doctors are in medicine only for the money and prestige; and 61% thought that doctors do not spend enough time with their patients. We can console ourselves by thinking that patients still love us, but I think they are sending us an urgent message.

The increasing economic pinch engendered by the new environment is forcing physicians to scramble for the shrinking base of patients. Physicians are advertising more, attending more market seminars, joining or forming their PPOs, IPAs, and PPOs, opening walk-in clinics, consorting with hospitals and insurance companies, and exploring every opportunity to preserve their share of patients. Never before has the medical community been in such ferment over the brewing economic storms.

Amidst all these developments, physicians are worried about what will happen to the quality of medical care. It is a legitimate fear. Sporadic reports of shortcuts in patient care, premature discharges of patients, and rationing of medical care are an ill omen of what may be coming. Studies are in progress to make sure that such things do not happen routinely; in the meantime, physicians are hoping that the new system is not going to breed all the evils that other countries like Great Britain and Canada have experienced. The ghost of history will haunt those who have not learned its lessons.

It is an interesting period in the history of medicine; at the same time, it is fraught with portents that happy days may not be here again.

R. G. Lacsamana, M.D.
Editor

Malpractice relief: is it coming?

In a representative democracy, elected officials must try to solve constituent and societal problems as efficiently and economically as possible, because individuals and groups can no longer solve many problems themselves. Laws are enacted in response to such requests for assistance.

For over ten years, the Florida legislature ignored rising costs of professional liability insurance and health care, and pleas from physicians and hospitals to investigate and ameliorate the on-going malpractice crisis. Elected leaders chose to interpret supplications from physicians as just one more aspect of the battle between physicians and lawyers in their mutual quest for power and cash.

There are some individuals, including a few well known and vocal plaintiff attorneys from South Florida, who vehemently deny that a malpractice crisis really exists, and if they are correct then there is no reason to institute major legislative changes. But why are so many insurance and reinsurance companies either going bankrupt or ceasing to write professional liability coverage for physicians in Florida, and why are neurosurgeons, anesthesiologists and obstetricians being asked to pay 70 to 90 thousand dollars a year for coverage, and why are physicians assigned to the JUA high risk pool in those same high risk specialties being asked to pay an annual premium of two hundred thousand dollars or more?

A CBS television news report on malpractice discussed the possibility that the crisis is being created by insurance companies, which, it was alleged, are accumulating billions of dollars in profits while insisting on higher premiums each year. If this is true, then it is the job of state government or Congress to investigate insurance companies to find out the validity of these allegations. A neurosurgeon in Tampa or an obstetrician in Miami, struggling with an annual premium of ninety thousand dollars, and a busy operating and office schedule, has neither the time, expertise, nor authority to question the insurance industry about its policies.

Physicians in Florida, led by the Florida Medical Association, have worked hard for ten years to obtain legislative relief and were able to have several important pieces of legislation enacted, including the creation of medical mediation panels which functioned efficiently until they were declared unconstitutional by the Florida Supreme Court. The panels were a creative and equitable way to filter out unworthy suits and increase the chance for an out-of-court settlement. Almost identical mediation panels still function in other states where they have not been challenged by the judiciary.

The creation of the Florida Patient's Compensation Fund by the Legislature, although perhaps conceived with good intentions, was enacted to provide umbrella coverage for physicians and hospitals in the midst of rising premiums and million dollar awards, without really addressing the basic defects in the tort system. By neglecting to set limits on liability, however, the Legislature exposed the PCF and all their clients to bankruptcy and ultimate failure which did occur, and physicians and hospitals are still paying assessments for years during the late 1970s and early 1980s when the PCF was providing umbrella coverage in the face of multi-million dollar jury awards. When it went out of existance, the PCF left small insurance companies and self insurance trusts with unlimited assessability, a devastating situation that ended when large reinsurance companies, like Northstar and Lloyds of London, decided to participate to fill the void, but at great increase in cost of protection.

After the 1983 legislative session, with no help in sight for any significant relief, the Florida Medical Association decided to by-pass the Legislature by going directly to the electorate with a referendum for constitutional reform. Over 700,000 signatures were obtained to place the referendum on the ballot, but because of possible legal errors in their preparation, the Florida Supreme Court removed it from the ballot several weeks prior to the November 1984 election.

The degree of concern expressed by nearly three quarters of a million citizens of this state as signatories of that referendum, and the almost total unwillingness of elected representatives to address the matter in a constructive way, prompted the South Florida Health Action Coalition to empanel a group of prominent Floridians to hold hearings around the state from October 1984 through February 1985, culminating in recommendations to the Legislature at the beginning of the 1985 session. The panel obtained its financing, authority, and prestige from its members: executives and officers from a large number of private and public companies and municipalities from around the state, who were very much aware that the malpractice crisis was severely increasing the cost of conducting business in Florida.

Governor Graham responded to the increased public interest created by the FMA referendum and appointed his own panel of experts to hold hearings and make recommendations to the Legislature. The creation of a second panel, however, was expensive and duplicative and it would have been less expensive and more productive had legislative leaders themselves established a fact-finding commission to hold hearings and make recommendations to the full Legislature.

The 1985 legislative session started with a flurry of activity when House Speaker James Harold Thompson openly expressed interest in passing malpractice legislation. He asked Rep. Tom Gustafson (D-Broward), Chairman of the House Health Committee, and Rep. Art Simon (D-Dade), Chairman of the Subcommittee on Medical Malpractice, to prepare a house bill with enough innovative changes to ameliorate the crisis, yet appease all protagonists in the face of the predicted lobbying efforts by physicians, trial attorneys, and consumers, including the so-called victims of malpractice who traveled to Tallahassee at the clandestine expense of the plaintiff bar to publicly deride and embarrass the medical doctors of this state.

The subcommittee, which labored tirelessly for almost the entire legislative session, produced a 115-page house malpractice bill, which was presented to the Senate in the closing days of the session. While the house bill was not, and could never be exactly what physicians believed is necessary to correct the malpractice crisis completely, it dealt fairly with many areas of physicians' concern.

It is interesting to note that in prior years it was the Senate which wrote malpractice legislation and the House which traditionally presented stumbling blocks, but during the final days of the 1985 session, the Senate seemed intent on destroying the entire 115 page house bill without offering any compromise or legislation of its own. On Thursday, May 30, the Miami Herald reported that the malpractice bill was dead because the Legislature was intent on adjourning one day early, on Thursday night, reportedly to save taxpayers' money. In the last hours of the session, reportedly in return for ending opposition to the Mayo Clinic bill, Senate leaders promised physicians the passage of malpractice legislation, and the result is HB 1352.

To summarize some important parts of HB 1352: 1) setting of community standards for expert witnesses; 2) sliding scale for attorneys' fees; 3) structured settlements which are mandatory for future damages of over a half million dollars; 4) 90 day cooling-off period, coupled with arbitration; 5) increased immunity for hospital boards and peer review committees; 6) increase in Board of Medical Examiners by one member to 12; 7) loss or settlement of three or more suits within five years of $10,000 or more is now a ground for discipline by the Board or Medical Examiners; 8) contributory fault which does not eliminate joint and several liability but makes each defendant responsible for only proportionate share of damages for any defendants from whom the judgement cannot be collected; 9) requirement of hospitals to have risk managers and competent medical staffs, and imposition of liability on hospitals for failing to use due care in these obligations; a hospital may purchase a comprehensive umbrella PLI policy for itself and its staff, with optional staff participation; 10) grounds for license restriction for physicians who order diagnostic tests that are not reasonably calculated to assist the health care provider in caring for the patient; 11) mandatory PLI of $250,000/$750,000 for physicians with hospital staff privileges and $100,000/$300,000 for those who do not belong to any hospital staff. This becomes effective on January 1, 1987; 12) 60 hours Category I CME every three years, as condition of medical licensure; 13) a valid medical license to obtain professional occupational license in any city or county in Florida.

There are many parts of HB 1352 which I have not addressed here at all, including some that may be important to individual physicians around the state, and I urge every physician to obtain a copy of this law and read it thoroughly. Dr. Luis Perez's President's Memo of June 11, 1985, mailed to all FMA members, discusses HB 1352, and includes a detailed evaluation of the entire law, as well as per-

tinent comments by Dr. Perez. He believes that physicians have gained a great deal through this legislation, and although the Legislature failed to place a cap on general damages or eradicate joint and several liability, it does represent the beginning of a solution to a malpractice crisis that has persisted unabated for over ten years. I join Dr. Perez in thanking Reps. Simon and Gustafson, Senator Mattox Hair (D-Duval), House Speaker James Harold Thompson and Senate President Harry Johnston for all that they have done in initiating this solution to a nightmare for physicians that began over a decade ago. We should begin making plans now for the 1986 legislative session when we can request legislative refinement and additional changes in the malpractice laws that govern this state.

Richard J. Feinstein, M.D.
Miami
Contributing Editor



AIR FORCE

A great way of life.

READY FOR A CHANGE OF PACE?

The Air Force has openings for physician specialists. You can enjoy regular working hours, 30 days of vacation with pay each year, worldwide travel opportunities and a unique and enjoyable lifestyle for you and your family, while serving your country. Ask a health professions recruiter about our outstanding pay and benefits package. Contact:

SMSGT Jim Dotson
464 S. Orange Blossom Trail
Room 408
Orlando, Florida 32809
(305) 420-6068

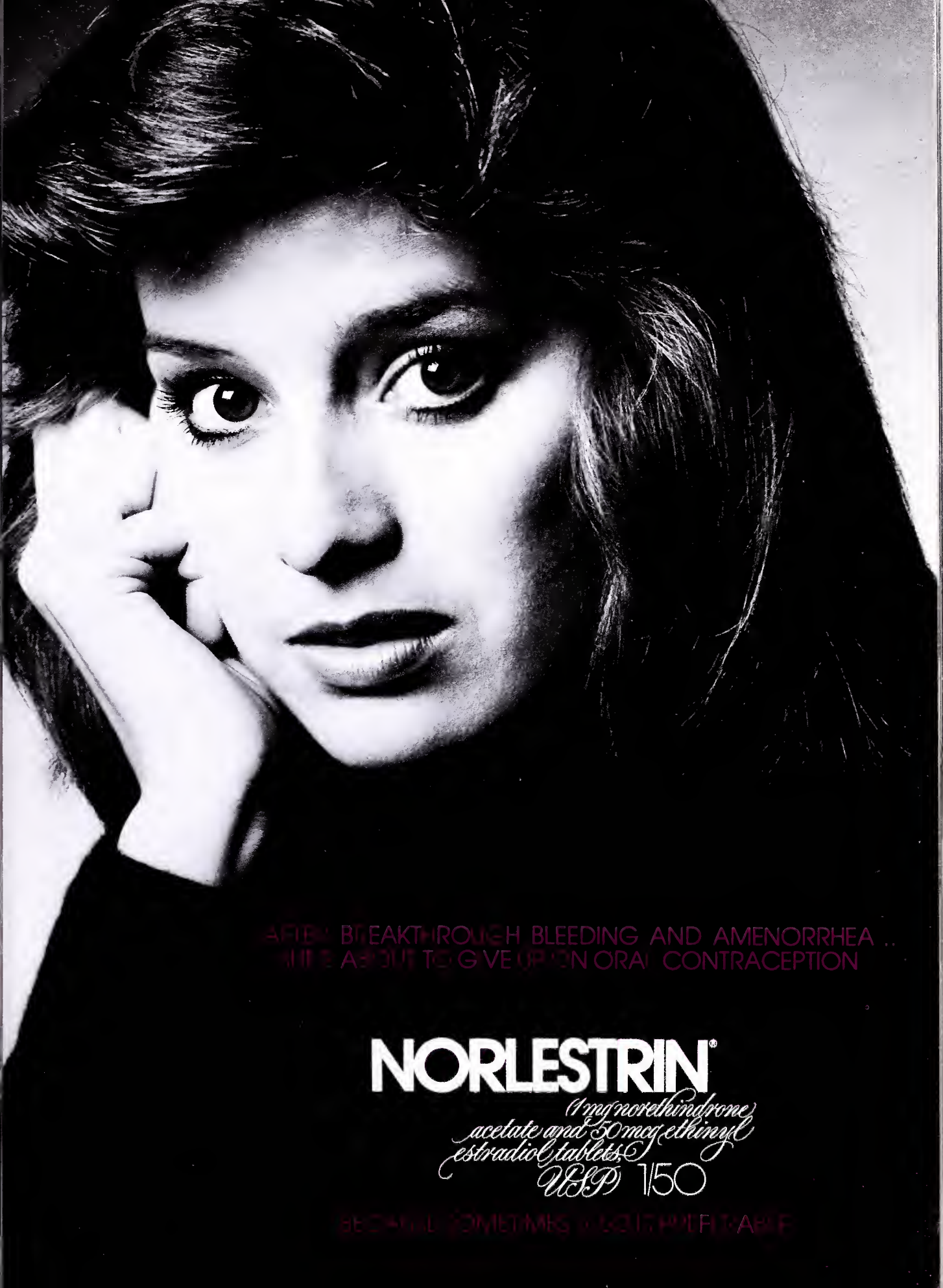
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.




BREAKTHROUGH BLEEDING AND AMENORRHEA ..
ABOUT TO GIVE UP ON ORAL CONTRACEPTION
NORLESTRIN®
1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP
1/50

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives; however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision, onset of proptosis or diplopia; papilledema; or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives; however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.

2. Preexisting uterine leiomyomata may increase in size.

3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.

4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.

5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.

6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.

7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.

8. Serum folate levels may be depressed.

9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.

10. Certain endocrine and liver function tests and blood components may be affected.

(a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis, cerebral hemorrhage; hypertension; gallbladder disease, benign hepatomas, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma, breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome, headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin 21 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin 21 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin Fe 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin FE 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin 28 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

0901G131

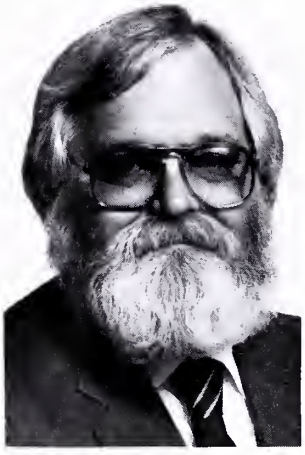
PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

© 1985 Warner-Lambert Company

PD-21-JA-2563-P-1(11-84)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
JULY 1985 Vol. 72, No. 7

Child abuse: old problem, new perspectives



There has been an exponential increase in reporting of child abuse and neglect in Florida over the past several years. This appears to reflect an increase in incidence and certain individual types of abuse have increased. Recognition and awareness, however, are key factors leading to the greater numbers of reported cases.

There is temptation to believe that child abuse is a problem of modern society but maltreatment has been practiced since the beginning of recorded history. Children were considered as chattel and, therefore, subject to the will or whim of parents. During several periods in history, infanticide was an accepted practice to deal with the overextended resources of society or similarly of an individual family. Nearly everyone is aware of child exploitation during the industrial revolution, the "spare the rod, spoil the child" philosophy of the Calvinists and Puritans, and the selling of children into a variety of types of bondage. Child abuse, therefore, is not a new phenomenon, but the recognition of children's rights has made a significant difference in the systems responsible for their welfare.

In 1874 the famous case of Mary Ellen in New York brought the issue of child abuse into focus. This child was being grossly maltreated by foster parents and there were no existing laws to protect her. Judicial relief sought under laws to prevent animal cruelty led to development of the Society for the Prevention of Cruelty to Children as an outgrowth of the Society for the Prevention of Cruelty to Animals. This development is the genesis of social work awareness of the problem of child abuse.

Medicine took longer to recognize the problem of abuse and neglect. In 1946 and 1955 reports appeared in the literature suggesting a connection between injuries and parental maltreatment. In 1962 when Henry Kempe coined the term "Battered Child Syndrome" medicine officially recognized the connection between child injuries and nonaccidental parental causation.

Child abuse is endemic and the only change recently has been a reluctant awareness of its presence. This fact coupled with a sense of children's rights has resulted in recognition of a need for action. It should be kept in mind, however, that we continue to provide mixed messages. Child abuse is only one form of of violence. We declare that violence against the child is wrong, but continue to maintain that violence is acceptable on television, in movies and even in schools. Role models are critically important in child development and mixed messages lead to developmental confusion.

Florida took an assertive position in protecting children by development of the statewide Child Abuse Reporting Hotline in 1971, development of Child Protection Teams in 1978, and allocation of Child Abuse Prevention funds in 1982. Many people in the state do not realize that our team system is unique. There are many child protection teams but none are linked into a statewide system directed by a pediatrician and utilizing the medical model for operation. The initial allocation of funds was to the Children's Medical Services program, Department of Health and Rehabilitative Services, and the entire system was designed and continues to operate under that program office. This administrative arrange-

ment—child protection teams as a medically directed service—is also unique in the country.

There has been upgrading of legislation for child protection every year by the legislature. The state is now seen as a leader in innovative programs for protection and abuse prevention. Concomitant with these improvements, there has been an expanding body of expertise in all areas. Many national and regional experts are recognized in this state and their work continues to be supported by Children's Medical Services. The products of some of these experts are included in this issue of *The Journal* and as we continue to expand our efforts in research more are expected to follow.

J.M. Whitworth, M.D.
Guest Editor
Associate Professor of Pediatrics
University of Florida
State Consultant
Child Abuse and Neglect
Children's Medical Services

Child abuse by burning

Alison H. Watkins, A.R.N.P.; Richard J. Gagan, Ph.D., and J. Michael Cupoli, M.D.

ABSTRACT: Surveys of child burn victims report that from 6% to 28% have known abusive etiology. Since causes are difficult to detect with many types of burns, these figures may underestimate the true incidence. Criteria are delineated for detecting abuse from various types of burns. Certain burns such as contact and immersion scalds may leave characteristic markings. By comparing the probable mechanism of the burning with the history of the developmental skills of the child, the physician usually can determine whether the burn was caused by abuse. Since the consequences of burn abuse to children are profound, including a death rate as high as 30-40%, the medical practitioner should be cognizant of the responsibility for careful examination and reporting. Children most at risk live in nonintact families that are mobile and have histories of employment difficulties and domestic violence. Children are especially vulnerable to hot water scalds and the public should be advised to limit hot water heaters to 120°. Citizens of sunbelt states should be educated concerning the potentially dangerous heat levels of automobile seats and restraining belts.

The Authors
ALISON H. WATKINS, A.R.N.P.
RICHARD J. GAGAN, Ph.D.
J. MICHAEL CUPOLI, M.D.
Ms. Watkins is presently employed as an instructor in Pediatric Nursing at the University of South Florida College of Nursing, and has experience in child abuse. Dr. Gagan is a sociologist and Associate Professor in Developmental and Behaviorial Pediatrics in the Department of Psychiatry, University of South Florida College of Medicine. Dr. Cupoli is Associate Professor of Pediatrics and Director of Child Development and Behavior, University of South Florida College of Medicine.

Burn injury is a traumatic event for a child and his family. The human suffering is immeasurable and treatment is often extremely costly and lengthy. Inflicted burns are an integral part of the battered child syndrome, yet experts believe numerous cases pass for accidents.[1-7] Increased awareness of abuse as a factor in burn etiology will decrease the risk of further injury to the child, decrease the potential risk of injury to his siblings and facilitate therapeutic intervention. When a burn of abusive etiology is unrecognized, the cost may well be a child's life.

Epidemiology • The true incidence of child abuse by burning is unknown. Epidemiological studies may present the likelihood of burn abuse through two types of conditional probabilities: proportion of burns among abused children (Table 1) and proportion of abused children among those presenting with burns (Table 2). Both types of surveys report an incidence of inflicted burns ranging from 6% to 28%. The varying statistics reported in the tables probably can be accounted for by differing thresholds of recognition. Obvious inflicted burns such as those caused by cigarettes, hot irons or radiators are rarely overlooked. Intentional scalding injuries, however, are similar in appearance to accidental burns and they may not be recognized as inflicted. Minor burns not requiring hospitalization but perhaps of abusive etiology are not included in these surveys. Thus, the stated incidence of burn abuse is likely to be an underestimation of its true occurrence. As many as 30% to 40% of burn-abused children die from their injuries, a mortality rate appreciably higher than when children are burned accidentally.[8,9] No explanation for this elevated rate is noted.

The most frequent cause of burn abuse is scalding with hot liquids. Of 25 cases Stone[2] identifies 15 (60%) scald burns, five (20%) hot metal contact

burns, and four (16%) flame burns. Hight[7] reports 87% of 142 burns as scalds and 13% as flame injuries. Sixty-seven percent of these nonaccidental burns occur in the kitchen or bathroom.

Chemical burns are not common manifestations of child abuse, although two cases have been reported.[1] We have seen a two-year-old girl with chemical burns to the vulva caused by lye. In the British literature, the history of a Cetrimide cleanser burn to an infant appears suspicious of abuse because of family history, but is not noted as such.[10] Burns from chemicals are often third degree because the tissue destroying capacity is present until the chemical is removed. There are no reports of child abuse by electrical burning in the literature. Several abusive instances of frostbite are reported. Although less frequent, frostbite injuries have the potential of being as severe as those caused by heat.[18]

Burn mechanism ● The depth of a burn is a function of the temperature of the burning agent, exposure time, and thickness of the skin. Moritz and Henriques[19] note a reciprocal relationship between temperature of the agent and skin exposure time to the depth of the resulting burn. At a temperature of 49 C (120 F) liquid will not cause a full-thickness burn until the skin is exposed for ten minutes. Temperatures of 53 C (127 F) produce full-thickness burns with skin exposure of only two minutes. Young children's skin is appreciably thinner than that of adults. They sustain more severe burn damage with shorter exposure time and lower temperatures. At temperatures greater than 130 F, children can burn in about one-fourth the time of adults.[20] Handicapped persons with paralysis or sensory loss are also extremely vulnerable to burns because of their anesthesia, thin skin, and lack of mobility. The mean hot water

Table 1. — Child Abuse Surveys Including Inflicted Burns.

Source	Year	Span of Years	Number Abused Children	Number (%) Burn Abused Children
Lauer[11]	1974	1965-1971	130	16 (12)*
Stone[2]	1970	1965-1969	245	26 (11)
Lenoski and Hunter[12]	1977	1966-1977	712	43 (6)
O'Neill[13]	1973	1968-1973	110	31 (28)
Smith and Hanson[3]	1974	1971-1973	134	23 (17)
Hight[7]	1979	1971-1977	1518	142 (9)
Springthorpe[14]	1977	1973-1975	30	6 (20)

*Not including minor burns.

Table 2. — Burn Surveys Including Inflicted Burns.

Source	Year	Span of Years	Number Burned Children	Number (%) Burn Abused Children
Feldman[15]	1978	1963-1976	56*	16 (28)*
Hight[7]	1979	1972-1977	872	142 (16)
Ayoub and Pfeifer[16]	1979	1974-1976	26	5 (19)
Bakalar[8]	1981	1978	177	25 (14)
Fowler[6]	1978	1977-1978	300	17 (6)
Glasheen[19]	1983		396	34 (8)

*Tap water scalds only.

temperature in a survey of households in Seattle was 61 C (142 F). At this temperature, a ten second exposure to tap water results in a third degree burn to adults.[15] In Seattle, Feldman and his colleagues instigated a major public awareness program to reduce hot water heater thermostat settings. A similar prevention effort in Tampa has met with only limited success.

Detection • Abusive contact burns are generally recognizable but differentiation between accidental and inflicted scald injuries may be difficult. Although specific burn patterns of inflicted injury may not exist in all cases of abuse, Lenoski and Hunter[12] identify four specific patterns which, if present, can assist the professional in identifying burn abuse. These are (1) immersion burn with or without spared area, (2) splash burn, (3) flexion burn and, (4) contact burn.

Immersion burns result when a child is forcibly held in a hot liquid. A uniform burn occurs in all areas exposed and a clear line of demarcation exists distinguishing areas of tissue exposed to the hot liquid and those not exposed. By positioning of the body, the demarcation lines can be made parallel, thereby allowing an estimate of the child's position at the time of immersion. In some forced immersion burns, doughnut-shaped patterns result with a central area of spared tissue. This pattern of burn injury occurs because the spared area is forcibly compressed against the bottom or sides of a container, thereby avoiding prolonged contact with the hot liquid. No area will be spared if the container of liquid is located on a heated element.

When the hot liquid is poured or thrown, splash burns result. The depth of splash burns is less than with immersion burns because the liquid cools as it falls and is in contact with the skin for a shorter period of time. The burn depths are nonuniform and there are often multiple noncontiguous burn areas. The force of gravity, as the liquid falls, produces an arrowhead configuration to the burn allowing an analysis of the position of the child's body and the direction from which the liquid came.

Accidental scald burns are usually asymmetrically distributed and only of partial thickness if treated promptly.[9] These burns are frequently on the front of the body caused by the child pulling over a container of hot liquid and some of the superficial splash burns are irregularly distributed.

Flexion burns occur when a burning agent is produced while the child's hips or other parts of the body are in flexion. A zebra-like striped configuration of the burn results because the flexed areas are protected from contact with the hot liquid. Areas commonly spared in this manner are creases anterior to the hip area and lower abdominal wall.

In contact burns, the burning agent such as a cigarette or iron is placed on the skin long enough to produce at least a second degree burn. In deliberate abuse, the configuration of the burn is that of the burning agent. In accidents, the contact agent is usually brushed against, thereby leaving an imperfect mark. For example, an accidental cigarette burn will not have the clear round shape of the abusive burn.

Information obtained during history-taking may assist the physician in determining the burn etiology. Often the parents' historical accounts of the injury will vary and may change over subsequent tellings. The parents may be evasive and the injury may be attributed to a sibling or babysitter. Frequently there is a delay in seeking medical care and often an unrelated adult brings the child for medical treatment. When a parent is present, he or she may display inappropriate concern or lack of concern for the child's condition. Finally, burn abused children appear passive, introverted and overly fearful.[7,18]

Location of burns • Locations of burns also aids the practitioner in identifying abuse. Immersion burns resulting in "stocking" or "glove" distributions occur when the extremities are forcibly held in hot liquid. These "mirror-image" burns are usually symmetrical and uniform in depth. While being held, the child is unable to splash, so satellite or noncontiguous burns usually are not present.[18] Several authors report a high incidence of abusive burns to the perineum and buttocks and these burns should be considered abuse unless otherwise proven.[2,18,21] Burns of the posterior aspects of the head, neck, chest and extremities are rarely self-inflicted and should arouse suspicion of willful injury.[1] The absence of a burn to the axilla or submental area with a history of the child pulling hot liquid over also requires extensive etiological investigation.

No consistent relationship between the extent of a burn and the etiology of abuse exists. It is noted, however, that death is more likely from abusive burns than from accidental burns.[9,15] First degree burns occur infrequently in burn abuse because the child is unable to remove himself from the burning agent resulting in longer exposure and a deeper burn. Two-thirds of the children in Gillespie's[1] sample had second degree burns while the remaining evidenced third degree. Tapwater scalds, regardless of etiology, tend to be more extensive than other scalds, involving approximately two times the mean body surface.[20]

Several additional characteristics of burn abuse are reported. A high incidence of previous injury in both the burned child and his siblings is noted.[1,7,11,13] Burn-abused children frequently present with multiple stigmata of abuse and neglect including burns of varying age. Bruising, fractures, damage to the central nervous system, and malnutrition are commonly associated with burn abuse.[1,13,16,18]

Errors in detection — False positives • While a heightened index of suspicion of abuse is essential to safeguard the welfare of children, the professional must explore all possibilities before a final determination of etiology is made. Five cases of suspected abuse described by Schmitt[22] were found to be accidental second degree burns which occurred when infants came into contact with surfaces heated by the sun. Several of the children were burned by vinyl upholstery and one was burned by the buckle of a bicycle safety strap. Dark-colored surfaces become as much as 30° hotter than light-colored ones when exposed to the same radiant sunlight.[22] In Florida, recent legislation has made it mandatory for infants and children less than age six to use some kind of seat restraint while in an automobile. The use of car seats by new parents in Florida and other sunbelt states may increase the incidence of car seat burns. Factors pointing to an accidental burn of this nature are the burn located on an exposed aspect of the body, history of dark colored seat upholstery and a recent auto or bicycle trip on a bright, sunny day. Further evidence of the nonabusive etiology of such burns is that parents seek medical care within a reasonable time period. Knowledge of the burning potential of items left in the sun is of importance to inhabitants of sunbelt states.

Cupping is noted to be a cultural etiology of burns.[23] In this instance, a heated glass was applied to several locations on the child's back as a medical folk remedy. Allergy to the cleanser Cetrimide is also found to present as nonaccidental burn injury.[24] Cigarette burns and bullous impetigo are similar in appearance. Cigarette burns, however, usually heal with a scar, whereas impetigo lesions do not.

False negatives • Failure to detect abusive burns can occur when the physician is not the initial caretaker. The practitioner may be loathe to intrude on the child after the burns have been bandaged. Due to the serious risk of abuse repetition, however, direct examination should be scheduled along with planned unwrapping. Pain medications given previous to the unwrapping will help to relieve the discomfort of both the child and physician. The examination should be repeated again in seven days to verify the well-known patterns.

Clinical experience leads us to estimate that etiology can be determined by physical examination in approximately two-thirds of the cases. These cases are about equally divided between abusive and accidental causes. The remaining cases require further evidence from the required home evaluations and psychosocial histories.

Demographic characteristics of children • The demographic characteristics of children with inflicted burns are similar to those found in other forms of mistreatment. Burns and burn abuse occur more frequently in boys than in girls. Stone[2] notes that 20 of 26 inflicted scald burns occurred in boys while Feldman[15] and Hight[7] report the incidence of burn abuse in boys to be twice that of girls. The modal age range of burned children is 13-24 months.[2,7] As with other forms of child abuse, psychological disturbances and physical defects may be consequential. The extent of physical scarring is dependent on the depth, location and extent of the burn. Multiple hospitalization for scar revisions and release of joint contractures may be necessary. Certainly the psychological trauma of a burn and the high incidence of associated battering in burn abused children can be expected to impact on their normal growth and development.[25]

Studies concerning emotional scarring of child burn victims are inconclusive.[26-29] Woodward[26] reports a follow-up study of 198 burned children showing a statistically significant (81% vs 14% in an unburned control group) incidence of emotional disturbances three years after recovery from the injury as reported by the mothers. Wright,[28] however, fails to show differences on a variety of psychological tests administered to burned children and a control group. Sawyer[29] finds that adolescent burn victims evidence poorer psychosocial adjustment than do younger children. The authors caution that even an apparent good adjustment by a young child does not preclude later emotional problems, especially during the tumultuous adolescent years.

No studies of emotional scarring of burn-abused children are published. In the hospital, however, these children appear passive, introverted, and fearful of incurring further injuries from strangers. They tend to remain withdrawn in their beds and do not seek contact with the other children. They exhibit a flattened effect and do not generally cry or resist their treatments. Initially these children are unresponsive to friendly overtures by the staff but over time, as trust develops, dramatic changes in their responsiveness are seen.[7]

Demographic characteristics of the parents • The demographic characteristics of the parents of burn-abused children also are similar to those described for other types of abuse. The problem is not confined to the poor but crosses all socioeconomic levels.[1] Feldman[15] and O'Neill[4] report, however, a higher incidence of scald burns among the lower socioeconomic groups. While Lauer[11] notes more abuse occurring in white families, most studies do not find race to be a factor in willfully inflicted burns.

Often environmental and psychiatric stress are antecedents to childhood burns and accidents.[30,31] Hight[7] finds the majority of families to be single (48%) or divorced or separated (27%). Severe marital stress is noted in all of the cases of burn abuse

reported by Ayoub and Pfeifer.[16] Maternal characteristics include isolation, suspiciousness, rigidity, dependence, immaturity and a lack of empathic mothering. Burn abuse families are more likely to be excessively mobile, have histories of employment difficulties and of violence in the home.[16] Alcohol and drug abuse are found to be associated with burn abuse.[1] While Keen[21] remarks on the possibility of parental mental illness due to the heinous nature of burn abuse and Gillespie[1] notes manifest psychosis in eight of the abusing parents, most studies do not find mental illness to be a predisposing factor to burn abuse. In the hospital, abusing parents reveal inappropriate or detached emotional concern for the child. Frequently they abandon the child after admission and use the telephone to check on the child's condition. Failure to seek immediate medical care for the burned child also has been noted as a characteristic behavior of abusing parents.

Discussion • The repetitive nature of burn abuse in association with other forms of maltreatment without intervention places a child at high risk for further injury and even death. Recognition of inflicted burns requires astute professionals with a high index of suspicion and the performance of a careful history and physical examination. The exact details of the incident should be recorded and considered with a critical assessment of the depth, extent and distribution of the burn along with the developmental age of the child. A detailed developmental history will assist the physician to ascertain whether the child is developmentally mature enough to have caused the injury. Analysis of the depth, configuration, distribution of the burns, and the reciprocal relation to flexion creases and joints of the spared areas may allow for the detection of the body position at the time of the burn occurrence.[13] This information is a powerful tool for assessing the accuracy of the history and the likelihood of abusive etiology.

During the physical examination, careful inspection of not only the burn area but also the entire body is required. Frequently other stigmata of abuse and neglect will be present as well as recent hand or fingerprint bruises received while the child was being forcibly held. A skeletal survey should be performed to inspect for the existence of fractures.

Criteria for detecting the battered, burned child have been defined from the most common physical, historical and social findings.[7]

Physical findings:

1. History of burn incompatible with physical findings,
2. Burn incompatible with developmental age of the child,
3. "Mirror image" burns of the extremities,
4. Localized burns of the perineum, genitalia, and buttocks,
5. Burn assessed as older than historical account,
6. Unrelated hematomas, lacerations, fingernail marks and scars,
7. Unsuspected old, long bone or skull fractures found on skeletal survey.

Historical and social information:

1. Burn attributed to siblings,
2. Unrelated adult seeking medical treatment for the child,
3. Differing historical accounts of the burn,
4. Treatment delay of longer than 24 hours,
5. History of numerous prior accidental injuries,
6. Inappropriate or lack of parental concern,
7. Passive, introverted, fearful child.

When the history and physical findings suggest an inflicted burn, the law mandates a report of suspected abuse to the Florida State Child Abuse Registry. Unfortunately, professionals often are reluctant to report suspected abuse; perhaps because they are concerned about making moral judgments, increasing parental distress, and/or having to deal with increased tensions, hostility and manipulation from the parents once the report is made. Legally the report should be made as soon as abusive etiology is suspected. The report should be discussed with the family in a nonjudgmental fashion and its purpose of protecting the child explained. The professional should detail for the family what happens after the report, beginning with the investigatory visit from Department of Health and Rehabilitative Services staff. Acknowledging in a nondefensive manner the anger often expressed by parents may help to defuse the situation.

An intensive history of the injury, careful physical examination, and investigation of social characteristics are essential to burn abuse detection. By comparing the probable mechanism of the burning with the history and the developmental skills of the child, the practitioner can determine the etiology of the burn. Child abuse without intervention tends to be repetitive. When the abuse is repeated, the severity of the injuries always escalates over time. Given the vulnerability of young children, the professional must develop a high index of suspicion when treating burned children. When abuse is suspected, the practitioner must notify HRS and take the appropriate steps for intervention.

Acknowledgment

We would like to express our appreciation to Pat Lyons and Karen Garrett for their assistance in the preparation of the manuscript.

References

1. Gillespie, R.W.: Battered Child Syndrome: Thermal and Caustic Manifestations, Trauma 5(4):523-534, 1965.
2. Stone, N.H.; Rinaldo, L.; Humphrey, C.R., and Brown, R.H.: Child Abuse by Burning, Surg. Clin. Am. 50(6):1419-1424, 1970.
3. Smith, S.M. and Hanson, R.: 124 Battered Children: Medical and Psychological Study, Br. M. J. 3:666-670, 1974.
4. Ryan, M.G.; Davis, A.A., and Oates, R.K.: One Hundred and Eighty-Seven Cases of Child Abuse and Neglect, Med. J. Aus. 2:623-628, 1977.
5. Lung, R.J.; Miller, S.H.; Davis, T.S., and Graham, W.P.: Recognizing Burn Injuries as Child Abuse, Am. Fam. Physician 15(4):134-135, 1977.
6. Fowler, J.: Child Maltreatment by Burning, Burns 5:83-85, 1978.
7. Hight, D.W.; Bakalar, H.R., and Hoyd, J.R.: Inflicted Burns in Children, JAMA 242(6):S17-520, 1979.
8. Bakalar, H.R.; Moore, J.D., and Hight, D.W.: Psychosocial Dynamics of Pediatric Burn Abuse, Health Social Work 6(4):17-32, 1981.
9. Shaw, A.: Surgical Management in Child Abuse, In E.H. Newberger (ed), Child Abuse, Boston, Little, Brown and Co., 177-206, 1982.
10. Mercer, D.M.: Cetrimide Burn in Infant, Postgrad. Med. J. S9:472-473, 1983.
11. Lauer, B.; Broeck, E.T., and Grossman, M.: Battered Child Syndrome: Review of 130 Patients with Controls, Pediatrics 54(1):67-70, 1974.
12. Lenoski, E.F. and Hunter, K.A.: Specific Patterns of Inflicted Burn Injuries, J. Trauma 17(11):842-846, 1977.
13. O'Neill, J.A.; Meacham, W.F.; Griffin, P.P., and Sawyers, J.L.: Patterns of Injury in Battered Child Syndrome, J Trauma 13(4):332-339, 1973.
14. Springthorpe, B.J.; Oates, R.K., and Hayes, S.C.: Nonaccidental Childhood Injury Presenting at Hospital Casualty Department, Med. J. Aus. 2:629-632, 1977.
15. Feldman, K.W.; Schaller, R.T.; Feldman, T.A., and McMillon, M.: Tap Water Scald Burns in Children, Pediatrics 62(1):1-7, 1978.
16. Ayoub, C. and Pfeifer, D.: Burns as Manifestation of Child Abuse and Neglect, Am. J. Dis. Child 133:910-914, 1979.
17. Glasheen, W.P.; Attinger, E.O.; Anne, A.; Haynes, B.W.; Heibert, J.T., and Edlich, R.F.: Identification of High-Risk Population for Serious Burn Injury, Burns 9(3):193-200, 1983.
18. Jewett, T.C. and Ellerstein, N.S.: Burns as Manifestation of Child Abuse, In N.S. Ellerstein (ed), Child Abuse and Neglect, New York, John Wiley and Sons, pp 185-196, 1981.
19. Mortiz, A.R. and Henriques, F.C. Jr.: Studies of Thermal Injury: II Relative Importance of Time and Surface Temperature in Causations of Cutaneous Burns, Am. J. Path. 23:695-702, 1947.
20. Feldman, K.W.: Help Needed on Hot Water Burns, Pediatrics 71(1):145-146, 1983.
21. Keen, J.H.; Lendrum, J., and Wolman, B.: Inflicted Burns and Scalds in Children, Brit. Med. J. 4:268-269, 1975.
22. Schmitt, B.D.; Gray, J.D., and Britton, H.L.: Car Seat Burns in Infants: Avoiding Confusion with Inflicted Burns, Pediatrics 62(4):607-609, 1978.
23. Sandler, A.P. and Haynes, V.: Non-accidental Trauma and Medical Folk Belief: Case of Cupping, Pediatrics 61(6):921-922, 1978.
24. Inman, J.K.: Cetrimide Allergy Presenting as Suspected Non-accidental Injury, Br. M.J. 284, 385, 1982.
25. Gregg, G.S. and Elmer, E.: Infant Injuries: Accident or Abuse, Pediatrics 44(3):434-439, 1969.
26. Woodward, J.: Emotional Disturbances of Burned Children, Br. M. J. 1:1009-1012, 1959.
27. Long, R.T. and Cope, O.: Emotional Problems of Burned Children, N. England J. M. 264(22):1121-1127, 1961.
28. Wright, L. and Fulwiler, R.: Long Range Emotional Sequelae of Burns: Effects on Children and Their Mothers, Ped. Res. 8:931-934, 1974.
29. Sawyer, M.G.; Minde, K., and Zuker, R.: Burned Child — Scarred for Life? Burns 9(3):205-213, 1983.
30. Feldman, K.W.: Child Abuse by Burning, In H. Kempe and R. Helfer (eds), The Battered Child, U. of Chicago Press, pp 147-162, 1980.
31. Meyer, R.L.; Roelofs, H.A.; Bluestone, J., and Redmond, S.: Accidental Injury to Preschool Child, J. Pediatr. 63:95-105, 1963.

● Ms. Watkins, 84 Adalia Avenue, Tampa 33606.

The abuse of infants by manual shaking: medical, social and legal issues

Barbara A. Eagan, M.A.; Susan Whelan-Williams, B.S.W.; and William G. Brooks Jr., M.D., M.P.H.

ABSTRACT: In the early 1970s Caffey comprehensively presented the pathogenic nature of the manual shaking of infants to the pediatric community. The Whiplash Shaken Infant Syndrome (WSIS) has since received coverage in numerous publications. Experiences indicate that discrepancies appear in the interdisciplinary methodologies for managing such cases. Comparison is noted of observable variances in the management of cases of WSIS and typical child battering. The need for thorough multidisciplinary/interagency evaluation of all recognized cases of WSIS is discussed in conjunction with presentation of medical and psychosocial diagnostic criteria for WSIS secondary to child abuse. Relevant legal, medical and psychosocial issues are highlighted based on the observations and experiences of members of a hospital-based, multidisciplinary child protection team.

The Authors
BARBARA A. EAGAN, M.A.
SUSAN WHELAN-WILLIAMS, B.S.W.
WILLIAM G. BROOKS JR., M.D., M.P.H.
Ms. Eagan is a Case Coordinator/Training Coordinator; Ms. Whelan-Williams is the Program Coordinator, Orlando Regional Medical Center Child Protection Team, and Dr. Brooks is a Resident in Pediatrics, Orlando Regional Medical Center.

The Whiplash Shaken Infant Syndrome (WSIS) received the attention of professionals involved in the diagnosis and treatment of abused children in 1974 when John Caffey, M.D., published a landmark article in *Pediatrics*. Diagnostic criteria for pathogenicity of manual shaking in the whiplash syndrome were defined as "the most characteristic pattern of physical findings where there is no external evidence of trauma to the head, soft tissue of the neck and face of the facial bones and calavaria in conjunction with massive traumatic intracranial and intraocular bleedings."[1,2] In the ten intervening years since Caffey's publication, numerous reports have appeared in journals and the syndrome has received coverage in most anthologies on battered children.[3-7] Experience shows, however, that professionals in medicine, social science, criminal justice and law enforcement are hesitant to recognize shaking as an act of child abuse when perpetrated by a parent or designated caretaker. Most commonly, injuries received from shaking seem to be regarded as a sign of parental ignorance concerning the anatomical configuration of the infant head and neck rather than as a culpable act. Infants presenting with severe injury from acceleration/deceleration trauma are often viewed by the local state child protection agency and the juvenile and criminal justice systems as only slightly more in need of protective services than children who are injured accidentally, where the issue of parental negligence is so negotiable that only cursory intervention is routinely provided. Cases where injuries are the result of slapping or striking with an object (often with less severe physical sequelae for the child) are many times more aggressively pursued. Parent education is often proposed as a method of preventing similar injury. Periodically brief media campaigns are launched to

focus public attention on the danger of shaking very young children as a disciplinary tactic or attention-getting device. Certainly such educational pursuits are to be lauded, but are they enough? Are parents, who cause potential permanent injury to their children by shaking, themselves victims of a society which allows us to develop child rearing skills by trial and error, or do they fit the recognized characteristic pattern of persons prone to commit serious abusive acts toward children?[8] The implied debatability of these philosophies has led to major difficulties in development of acceptable management plans in several recent central Florida cases. It is our intent to document perceptions of the dilemma and the impact differing perceptual bases may have on treatment plans when compared with those developed by children who have suffered injury from other forms of inflicted trauma. The provision of concrete examples should provide impetus for future investigation and resolution of the issue.

As members of a hospital based, multidisciplinary child abuse team, we are involved in evaluation of approximately 100 children per month alleged to have been abused by caretaking adults. Assessment includes comprehensive medical and psychosocial evaluation, provision of treatment recommendations, and coordination of communication between the statutorily designated investigative parties (i.e. H.R.S. caseworker, law enforcement investigator, state attorney investigator and guardian ad litem). Formal information sharing and case planning staffings are done whenever there are differing opinions concerning treatment which cannot be resolved on an informal basis, and/or when case plans appear inadequate for protection of the child and treatment of the family. Such interagency meetings are required in WSIS cases far more often than in cases indicative of other types of inflicted trauma, although the prognosis for permanent damage is often more significant in the former than the latter. It has been our experience that the issue of culpability and intent seems to be consistently raised during discussion of WSIS but rarely raised when debating a course of action for other types of child battering.

Based on our observations, successful child protection and family treatment usually warrant intervention of both juvenile and criminal court systems when the inflicted injury is severe and the parents deny (or rationalize) their responsibility for the child's injury.[9,10] Voluntary plans seem to prove ineffective in these cases leaving the child at risk for reabuse. Research must be initiated to provide more than a hypothetical basis for such an argument. However, recent findings on husbands who abuse their wives indicate that recidivism is decreased when criminal charges are pressed by the victim.[11] We contend that the child with severe intracranial trauma resulting from manual shaking frequently fits both legal and sociomedical definitions of an abused child. Careful history taking will usually reveal intra-family dynamics identical to those found in other abusive families (e.g. low stress tolerance, generational pattern of abnormal child rearing practices, marital discord, and unrealistic expectations for children). The following section will present brief studies of two cases of shaken children and two cases of children injured by other means with presentation of physical findings, family dynamics and case plans. Discussion will focus on differences with implication for medical, legal and social case management, as well as on the need for development of a consistent conceptual base for the handling of WSIS by the various disciplines involved.

Case reports — Case 1 • This 11-month-old female presented to the emergency room after she was found lying on the floor comatose and in respiratory arrest. Initial physical examination was unremarkable except for bilateral retinal hemorrhages on funduscopic examination. A head CT scan revealed a subarachnoid hemorrhage. State child protective services and law enforcement agencies were notified; the multidisciplinary team was also consulted. The father reported that while in his care the child had fallen from a couch and was found unconscious.[12] The child's past medical history was unremarkable for serious illness; however, there was a history of several injuries during the month prior to hospitalization consisting of linear facial bruises covering the left cheek and ear (parent explained child fell from bed); two large bruises on the buttocks and lateral thigh (parent explained she fell on a supermarket scale); and a large area of soft tissue swelling on the forehead (also reportedly from a fall). During the child's hospitalization, the stepfather admitted that he had "shaken" the child to wake her up from a nap in an attempt to adjust her sleep schedule, and "slapped" the child to gain her attention.

The stepfather presented a history of childhood poverty, relocation and physical abuse. He prematurely quit high school to assist with family finances as both of his parents were disabled. Psychometric evaluation (MMPI) revealed a profile consistent with those of individuals possessing low stress tolerance and impulse control. The mother reported a childhood with many relocations, parental alcoholism and spouse abuse, maternal child abuse and parental divorce. She stated that, as an adolescent, she felt "unwanted," became involved in delinquent activities, and experienced an unplanned pregnancy which was terminated by abortion. She met and married her present husband only after giving birth to a daughter. Both parents reported marital disharmony, financial problems and significant discord in extended family relationships. At the time of referral the mother was in her third unplanned pregnancy.

The state child protection worker was hesitant to initiate juvenile court proceedings and felt that the family could be assisted through a voluntary plan. In addition, the law enforcement investigator refused to file criminal charges. A multidisciplinary staffing was called to discuss case plans. The potential for reinjury of the child was stressed by hospital team members by linking the serious nature of presented injuries, history of questionable accidents and the significant correlation of the parents' psychosocial profile with that of child abusing adults. State and law enforcement officials felt that the child could be protected through a short stay in shelter care while the parents initiated individual counseling and parenting education.

There was marked debate concerning the efficacy of such a plan. However, the child remained in shelter care for two months and was returned home under sporadic agency supervision.

A second referral was received two months later when the child was brought by paramedics to the emergency room lethargic and unresponsive to verbal commands. Radiographic studies revealed an acute subarachnoid hemorrhage coinciding with a four to five-day-old bruise on the left temple. Funduscopic examination revealed acute bilateral retinal hemorrhages. The stepfather reported that he became "angry" with the child after a toilet accident and "spanked" her. In an effort to comfort her, he "played" with her by "spinning her around" and subsequently noticed the child to be unresponsive and unable to stand on her own. She was removed from the parents and placed with her grandparents. State officials initiated civil procedures for severance of parental rights and criminal charges were filed against the stepfather.

Case 2 • This 7-year-old male presented to the emergency room by the state child protection worker with injury to his right buttock and thigh. The multidisciplinary team was contacted for evaluation. Acute bruises were noted to cover the child's buttocks and lateral right thigh with markings showing the clear delineation of a belt end; ten to 12 separate marks could be counted. The child's two younger brothers (ages two and five) were noted on physical examination to have less severe, though similar, marks to the buttocks. The child reported that on the evening prior to his emergency room visit he had lost a small digital clock and was hit with a belt, in his mother's presence, by her male companion. He stated this was one of many similar whipping episodes from his mother and her boyfriend. No signs of chronic trauma were noted.

Social history revealed multiple factors giving a generalized picture of family instability. The mother stated that this child presented "severe behavioral problems" and admitted using belts for discipline. Both the mother and boyfriend revealed a childhood history of physical abuse.

The children were taken into custody by the state agency and remained in care throughout juvenile eourt proceedings, subsequently returning home. Intensive in-home crisis counseling, individual counseling, agency supervision and parent education were provided. The boyfriend was arrested and charged with aggravated ehild abuse.

Case 3 • This 10-month-old male presented to the emergency room by paramedics who found the infant at home unconscious and in respiratory distress. A CT scan of the head revealed bilateral subdural and subarachnoid hemorrhages. Funduscopic examination revealed acute bilateral retinal hemorrhages. The state child protection worker was then notified along with the multidisciplinary team. The father reported that during the day of admission the child had been in his care and was placed in an armless chair while he (the father) lay down for a nap. He awoke to find the infant "crying, lodged between the couch and an end table." The baby was "placed back in the chair" and the father "left" the room. He again "heard crying" and stated the child appeared to have once more "fallen from the chair." Upon further questioning he indicated that he attempted to calm the child by shaking him back and forth. Radiological studies during the hospital course showed a healing fracture of the left radius and ulna. The child expired on the third day of hospitalization.

Evaluation of the siblings revealed healed loop marks on the legs of the four-year-old who was present with the father on the date of the case subject's injury. The sibling was questioned as to what occurred with his brother and stated that "Daddy killed him."

Psychiatric evaluation of the father revealed a history of chronic schizophrenia resulting in prior hospitalization. Outpatient treatment included administration of psychotropic medication. The father denied conscious memory of his childhood. The mother reported a steady employment history and a strong extended family support system. She reported previous violent acts by her husband toward herself and the children. She indicated that her husband was easily frustrated.

Initally state child protection officials and prosecutors were hesitant to initiate civil and criminal proceedings as they viewed the injury as unintentional and the result of poor judgement. An interagency staffing was held where the multidisciplinary team physician and medical examiner noted the injuries to be inconsistent with a fall and more consistent with shaking trauma.

The case was then presented to juvenile court and a plan of child protection involving the surviving siblings was ordered. The father was charged with second degree murder and pleaded guilty to the lesser crime of manslaughter; he received a seven year sentence.

Case 4 • This 2-year-old white female presented with circular area of several day old bruising covering her buttocks with linear bruising of the right lateral thigh. Child protection officials and law enforcement were contacted as well as the hospital-based multidisciplinary team. The mother stated the child had been left at a babysitter's home several days prior to the referral and due to a family emergency, the child was then cared for by an older female in the neighborhood. When the mother took back her child, she was noted to have a reddish swelling on both buttocks extending to the knees on the lateral aspect of her right thigh. The initial babysitter was questioned and revealed she had left the child with a neighbor during the day, who struck her with a wooden kitchen spoon for misbehavior. The babysitter readily admitted to striking the child and stated she did not realize she was "such an easy bruiser." Laboratory coagulation studies were within normal limits.

State officials investigated the babysitter's home situation and reported further action to be outside their jurisdiction (as the perpetrator was a nonrelative). The sitter, an older woman, was criminally charged with aggravated child abuse.

Eventually charges were reduced to misdemeanor battery during plea bargaining. The sentence included a course of probation, community service and a fine.

Discussion • Comparison of the four case studies makes it obvious that state child protection and criminal justice officials were hesitant to provide comprehensive intervention in the two cases of WSIS even though in both cases injuries were quite severe. In contrast, are the two cases of child battering involving older children who sustained bruises to the buttocks and thighs as a result of whippings by instrument (i.e. belt and wooden spoon) with less severe physical sequelae. Those cases were aggressively pursued, with family members receiving intensive therapeutic services and the offenders receiving criminal sentences. It should also be noted that cursory examinations of the two battering families

were undertaken with the presenting injuries seeming to be sufficient for intensive agency action. Conversely, both families in which the child presented with WSIS were intensely evaluated and evidence of abusive familial dynamics was significant (e.g. marital turmoil, prior history of violence, financial difficulties, low stress tolerance, and emotional instability). However, even in light of the combined factors, intensive advocacy was needed by the children's examining physician and other team professionals to insure an adequate plan of protection was initiated for the child. Certainly the aforementioned situations are not always exemplary of case action but such a scenario occurs with alarming frequency in cases of WSIS.

Summary • The Whiplash Shaken Infant Syndrome is a form of child abuse that presents multiple issues which must be addressed by those providing diagnostic and treatment services to children. The incidence of injury from manual acceleration/deceleration trauma is difficult to assess as many cases may go unrecognized. Those which are documented often appear to be associated with other forms of physical abuse (physicians' reports have ranged from 20 cases in five years to 20 in one year).[13] Published estimates indicate that 70% of the victims of WSIS either die or suffer permanent gross residual damage.[13] Caffey reports that acceleration/deceleration of the head of an infant is the most frequent cause of intellectual impairment and brain damage.[1] Any patient presenting to the physician with a history of convulsion and/or coma, evidence of intracranial and intraocular trauma in conjunction with a lack of visual signs of injury should be considered abused until proven otherwise. Physicians should insure that the child receives the benefit of medical care, thorough psychosocial assessment of family members, legal intervention and a multidisciplinary case plan. It is imperative that cases of WSIS be pursued in a comprehensive manner. If such an approach is ignored, the child will remain at risk for reinjury in many instances.

It appears that the most common motivation for the shaking of small children is the effort to discipline a child for actual or perceived misbehavior.[1] Many persons erroneously view such disciplinary tactics as more appropriate than striking children. However, any parental discipline which results in emotional or physical injury to a child is commonly recognized as symptomatic of abuse. Florida law requires physicians (and other persons) having reason to believe a child is abused to report such suspicions to the Department of Health and Rehabilitative Services. A failure to tender such reports is a misdemeanor.[9] Reporting suspected abuse provides impetus for a child protection investigation and thorough psychosocial assessment of family members. Those mandated to investigate allegations of possible abuse, in turn, instigate a criminal investigation by contacting law enforcement. Criminal justice officials concurrently determine if perpetrators have violated misdemeanor or felony statutes. Several investigative factors, relevant to cases of WSIS, should be discussed. Histories presented by caretakers during initial assessment are often inconsistent with the clinical picture. It is quite common to receive conflicting explanations concerning the etiology of the child's injuries, and it is not uncommon for explanations to change during the course of investigation. Presentations of multiple and inconsistent explanations, coinciding with dysfunctional family dynamics and medical evidence of trauma to the child, constitute a portion of the evidence for civil and criminal child abuse. The case studies in the foregoing portion of this paper provided concrete examples of such. Inconsistencies in statements can be presented as a factual base for the establishment of intent during court proceedings.[14] The use of subterfuge by the parent provides an argument that the perpetrator did, in fact, consciously understand that his actions could result in harm to the child.

The suggestion of an accidental component to WSIS is not without merit. Indeed, a number of cases reported could be classified as such and are thought to be the result of, for example, unsafe play procedures (such as rapid windmill swinging and tossing of infants) or an attempt to dislodge an object from a child's throat.[1] Although the aforementioned examples would probably not be classified as intentional abusive actions, they indicate a need for comprehensive educational conferences with the caretakers (a primary responsibility of persons who routinely deal with parents). In addition, Hispanic folk medicine practices have been documented in which a sunken fontanelle is treated by holding an infant upside down, with the head partially immersed in boiling water, slapping the soles of the feet and shaking.[15] The physician is not solely responsible for determining whether an injury resulting from manual shaking is accidental or abusive in nature. Other pertinent factors must be considered by the statutorily mandated investigating parties before an ultimate decision can be reached.

In conclusion, we suggest that WSIS secondary to abuse must be the initial diagnosis of exclusion in cases where overt head trauma is absent but is then discovered upon further examination in the form of head CT scan, funduscopic examination, etc. Routine funduscopic examinations should be included in all pediatric examinations and provide an excellent screening device for the timely diagnosis of WSIS.[1] A legitimate comprehensive approach requires thorough medical, psychosocial, and legal evaluation.

We contend that the shaking of infants and children is a serious form of child abuse and calls for recognition and aggressive intervention.

References

1. Caffey, J.: Whiplash Shaken Infant Syndrome: Manual Shaking by Extremities with Whiplash Induced Intracranial and Intraocular Bleedings, Linked with Residual Permanent Brain Damage and Mental Retardation, Pediatrics 54-4:396-403, 1974.
2. Caffey, J.: On Theory and Practice of Shaking Infants. Its Potential Residual Effects of Permanent Brain Damage and Mental Retardation, Am. J. Dis. Child. 124:161-169, 1972.
3. Morse, C.W.; Sahler, O.J., and Friedman, S.B.: A Three Year Follow-Up Study of Abused and Neglected Children, Am. J. Dis. Child. 120:439-446, 1970.
4. Bennett, H.S. and French, J.H.: Elevated Intracranial Pressure in Whiplash-Shaken Infant Syndrome Detected with Normal Computerized Tomography, Clinical Pediatrics 19-9:633-634, 1980.
5. Oliver, J.E.: Microcephaly Following Baby Battering and Shaking, Br. M. J. 2:262-264, 1975.
6. Guthkelch, N.: Infantile Subdural Hematoma and Its Relationship to Whiplash Injuries, Br. M. J. 2:430-431, 1971.
7. Ellerstein, N., (ed): Child Abuse and Neglect, A Medical Reference, John Wiley & Sons, Inc., pp 74-75, 1981.
8. Martin, H.: The Abused Child, Ballinger Publishing Company, pp 27-41, 1976.
9. Florida Statutes, Volume 2, Chapters 316-560. Ch. 415, Protection From Abuse, Neglect and Exploitation, 415.504; 415.503; 918-919; 415.511; 921-922; 415.513; 922, 1983.
10. Florida Statutes, Volume 3, Chapters 561-960. Ch. 827, Abuse of Children or Disabled or Aging Adults, 827.03, 827.04, 1393, 1983.
11. O'Reilly, J.: Wife Beating: The Silent Crime, Time 23-26, September 5, 1983.
12. Helfer, R.E.; Slovis, T.L., and Black, M.: Injuries Resulting When Small Children Fall Out of Bed, Pediatrics 60-64:533-535, 1977.
13. Curran, M.: Shaken-Infant Syndrome "Secret" Form of Child Abuse, Pediatric News 19-26, 1984.
14. Black's Law Dictionary, Revised 4th Edition: 947, West Publishing Co.
15. Guarnaschelli, J.; Lee, J., and Pitts, F.: Fallen Fontanelle: (Caida de Mollera) A Variant of the Battered Child Syndrome, JAMA 222-12:1545-1546, 1972.

Acknowledgment

We extend our appreciation to Doris Webber and Lavonna Newsome for their assistance in manuscript compilation and Danny Dawson, Assistant State Attorney, Juvenile Chief, for his comments on legal issues. This manuscript was funded in part by the Department of Health and Rehabilitative Services, Children's Medical Services.

● Ms. Eagan, Orlando Regional Medical Center Child Protection Team, 85 West Miller, Suite 304, Orlando, Florida 32806.

The incestuous family: profile and treatment plan

James J. Arnone, A.C.S.W., L.C.S.W. and Lawrence R. Leviton, M.D.

ABSTRACT: Incest in the family is a rapidly growing problem. The patterns of these families are different from those of families where other types of child abuse occur. These patterns are described. Effective treatment must include the entire family and coordination among the various agencies providing service. The conclusion recommends establishing specific laws for this abuse which will protect the child and allow for treatment of the offender and the entire family.

The Authors
JAMES J. ARNONE, A.C.S.W., L.C.S.W.
LAWRENCE R. LEVITON, M.D.
Mr. Arnone is Team Coordinator for the Child Protection Team, Inc., Riviera Beach, and Dr. Leviton is Medical Director.

Incest occurs when the parent, usually a father, uses his position of trust and authority to introduce the child into a secret sexual relationship. This often begins as a private game and progresses with exposure, kissing, genital fondling, and finally, but not necessarily, sexual intercourse.[1] Most cases coming to our attention involve fondling prior to intercourse. The sexual relationship has many "caring aspects" and is not primarily aggressive.

Legally defined, incest specifically describes intercourse with persons of close blood lineage. For treatment purposes, it may include stepfather, stepmother, stepbrothers and others with well established social ties. It may also include an array of sexual activity with the child. "The relationship is longstanding, with the adult having achieved a position of authority in the child's family as manifested through his active participation both in the family's decision making and their division of labor."[2]

Incidence • Estimates vary substantially regarding the exact incidence of incest and child sexual abuse. According to various researchers, "somewhere between 100,000 and 500,000 American children will be molested this year."[3] Most professionals agree that about one in four girls and one in ten boys are sexually abused in some way prior to their 18th birthday. The smallest proportion of child sexual abuse is made up of sexual contacts with strangers or less intimate family members. Eighty percent of abuse involves parents, usually the father, or other trusted relative and falls into the category of incest.[4]

Our experience in Palm Beach County where the treatment program has been in existence for more than two years shows a steady increase from six cases per month to a current average of 17; 580 families have been involved. The incestuous family

is in all socioeconomic groups, racial and religious backgrounds. Typically both parents are employed. Seldom is a member of the family known to any social or law enforcement agency.

Characteristics • A common characteristic of the families is social isolation. They have few community contacts. Contacts that do occur tend to be narrowly defined, for example, church or work related. These families tend to be mistrustful of "outsiders." The children are not encouraged to interact freely with friends and classmates. One mother vividly described her home as a "cocoon" which was seldom entered by those from the outside.

The incestuous adult tends to be socially timid and mistrustful. The men typically have low self-esteem and lack a sense of masculine identity. They try to compensate by projecting an image of male dominance. This results in tight controls and domination of both wife and children.

The communication patterns and sexual relationship of the husband and wife are unsatisfactory. Other factors may be involved including poor health, substance abuse, and minimal to absent sexual activity with the spouse. When both parents are employed, there are often different working schedules. This results in the father being left alone with the children.[5] He turns to one of the children, usually a daughter, in a desperate need for intimacy and control of his life.

The child may tell her mother. Some mothers reassure the child that they will discuss this with the father. Their interventions are ineffective. The mother may also fear risking a confrontation. The child soon realizes that she has no ally within her family. The mother continues to absent herself from her family believing the father's promise that he has stopped his sexual advances.

The sexual advances are bewildering to the child and usually the incestuous adult cajoles or frightens the child into secrecy. The inappropriateness of the situation is sensed by the child and progressively she fears disintegration of her family, fear of rejection of her friends, school, and finally the community. Often the relationship goes on for a period of years before she can tell a third party.

When the sexual abuse is finally revealed to law enforcement and child protection agencies, the mother expresses shock and disbelief. In many cases the father wants to be seen as a victim of the child's sexual advances. The parents often portray the child as seductive and sexually precocious.

Once the report is made, decisive external intervention is needed to break the control the perpetrator maintains over the family. The child must be reassured and the offender should be physically separated from the family. A coordinated intervention by professionals and agencies is essential. In most communities several agencies are involved with reports of child sexual abuse. These include: law enforcement, Department of Health and Rehabilitative Services (HRS), Sexual Assault Assistance Program, State Attorney's Office, and Child Protection Team.

Professionals must coordinate their intervention to reduce the trauma for the child. Instead of multiple interviews of the child, one planned (and ideally videotaped) interview is desirable. A physical examination should be provided if there is any indication of trauma to hymen and genitalia, possible venereal disease or pregnancy.

Due to secrecy of incestuous relationships, absence of witnesses and lack of physical evidence, these cases are rarely successfully prosecuted in a criminal trial. Moreover, the strong emotional and social ties between the offender and child will often increase the child's reluctance to testify against her father. Most children simply want the abuse to stop, to get relief from the emotional coercion she feels and help for her father and family.

Treatment • Because incest is most often symptomatic of severe family pathology, it should be treated through counseling.[6] We have found that the courts must be involved as an initial motivator for the family to enter treatment and to break the control the father holds over the family. Strong criminal sanctions such as imprisonment must be the consequence of noncompliance with treatment and other conditions of probation.

Treatment for the incestuous family must involve each member. We found that the key to success is counseling for the mother-daughter relationship. The mother is torn in her loyalties between her husband and child. There are also feelings of competition and guilt for not being more protective. This guilt is increased with mothers who had prior knowledge and did little to stop the involvement or did not believe the child.

The goals for the offender involve his accepting total responsibility, understanding of the reason for his behavior, and willingness to change his position of dominance in the family. If treatment is successful, he will be able to continue financial and emotional support of his family.

The goals for the child include development of more positive attitudes towards her own sexuality, and resolving her conflicting emotions regarding herself (as a victim), the offender, and her mother, who was not there when she needed her.

For the mother, the goals include sorting out her own feelings of guilt regarding development of the incestuous relationships. The mother must also resolve her ambivalent feelings toward her husband and daughter, and in the words of one mother, "get back my child again."

The siblings must understand their sister's innocence and not hold her responsible for the turmoil in the family. Finally the parents must come to resolution regarding the future of their family.

We have found that a planned sequence of therapies is needed to achieve these outcomes. These include: individual counseling for the child, mother and father; mother-daughter counseling; marital counseling if appropriate; father-daughter counseling; family counseling, and group counseling.

Case report • Susan is the 11½-year-old natural child of Ed and Barbara, the oldest of three children.

For the past three and a half years, the father admitted to fondling the child and kissing her between her legs. This act was discovered when the mother entered the bedroom and found her husband in bed with the child. She immediately reported the case to HRS and the Child Protection Team, Inc.

The father shows an employment history of many short-term jobs, and some alcohol abuse. He has low self-esteem. His relationship with his wife is poor and his behavior is impulsive. Since discovery of the incident, he accepts responsibility for his behavior but minimizes any effect it has had on the child. He stated, "She was sleeping when I fondled her." Barbara's initial response was of shock and anger. Initially she was unsure about ever seeing her husband again. Since she has been in treatment, she feels that her husband needs help and wants to emotionally support both him and her daughter.

At this time, the child is undergoing individual therapy and simultaneously the parents are involved in family therapy.

The father awaits sentencing and has been ordered into treatment which is focused on irresponsible behavior and on trying to understand the reasons for his dangerous and unlawful actions.

Ed has been court ordered out of the home. For any reunification to occur, marital/family therapy will have to continue until it is felt safe and desirable for family unit to come together again.

Program results • There have been 119 families in our treatment program since March 1983. Three offenders were sentenced to prison despite involvement with the program. In each of these cases the abuse was particularly damaging to the child. In addition, one offender decided on prison as opposed to community based counseling. His wife, however, has continued in the program.

Of the total families involved in treatment there have been three subsequent reports of a remolest of the child. Upon careful law enforcement investigation, two were found unsubstantiated. The third was valid and he has been returned to prison.

Unfortunately not all families enter treatment. Several factors contribute to this failure. We have observed two recurring themes. The first is the lack of coordination among agencies mandated to intervene in these situations. Without careful coordination, the child will feel confused, overwhelmed and not believed. She will feel that her desire for help is not forthcoming and will end involvement of these agencies by changing her story.[7]

The second factor affecting treatment is the application of laws such as "lewd assault" and "sexual battery" to the incestuous relationship. These laws connote violence, a sudden forceful act, and have little relevance to any incestuous families that come to our attention. These abusive relationships frequently have been going on for years. Several of the children we have worked with have voiced a similar bewilderment: "I don't like what father did, but that was the only time he showed me any affection." Application of these laws sometimes results in the child and family changing their story to protect the offender.

Laws are needed which include strong criminal measures such as imprisonment. Such laws are essential to protect the child from further abuse. So as to not cause further emotional damage for the child, these laws should initially allow for individual and family therapy ordered by the court. Our data show that the incestuous family can be treated successfully. The requirements for this success include a skilled and coordinated investigation; immediate safeguards to separate the incestuous relationships; and court mandated therapy including intensive group, individual and family.

Acknowledgment

Grateful appreciation is extended to Susannah Krehbiel, M.D., child psychiatrist, for her helpful suggestions with this article.

References

1. Sgroi, S.M.: Handbook of Clinical Intervention in Child Sexual Abuse, Lexington, Mass., Lexington Books, p 11, 1982.
2. Zaphiris, A.G.: Methods and Skills for Differential Assessment and Treatment in Incest, Sexual Abuse and Sexual Exploitation of Children, Denver, The American Humane Association (AHA), p 3, 1983.
3. A Hidden Epidemic: Sexual Ahuse, Newsweek, p 30, May 14, 1984.
4. Nakashima, I.I and Zakus, G.E.: Incest-Review and Clinical Experience, Pediatrics 60:696-670, 1977.
5. Zaphiris, A.G.: Conditioning Continuum Incest; The Family with Two Known Victims, Monograph, Englewood, Col., The American Humane Association, 1978.
6. Sgroi, op.cit., p 241.
7. Furniss, T.: Mutual Influence and Interlocking Professional-Family Process in Treatment of Child-Sexual Abuse and Incest, Child Abuse and Neglect 7:207, 1983.

• Mr. Arnone, Team Coordinator, Child Protection Team, 301 Broadway, Suite 212, Riviera Beach 33404.

Spasmus nutans occurring with child abuse/neglect

Samuel H. Moorer Jr., M.D.

ABSTRACT: Two cases of child abuse or neglect are reported, failure to thrive and severe and repeated injury. Both had head nodding, head tilt, and asymmetrical nystagmus, features of spasmus nutans. The etiology of spasmus nutans is controversial. It has previously been attributed to a disturbed maternal-child relationship, an etiology which seems likely in the cases presented. Diagnostic investigation of spasmus nutans is known to occasionally yield occult central nervous system tumors. Perhaps the presence of spasmus nutans should also stimulate investigation of family relationships and behaviors in order that child abuse and neglect may be diagnosed and treated.

The Author
SAMUEL H. MOORER JR., M.D.
Dr. Moorer is Medical Director of the Child Protection Team of HRS District II, and is a Pediatrician, Tallahassee.

Spasmus nutans is an unusual, rare, and obscure disease. The triad of head nodding, head tilt, and asymmetrical, often monocular, nystagmus is characteristic if not diagnostic;[1-3] however, instances of acquired transient unequal nystagmus without nodding or head tilt have been accepted in atypical cases.[1,4,5] Spasmus nutans typically begins in infancy and disappears spontaneously in weeks to months. The head bobbing has been noted to appear first with nystagmus following.[6] The nystagmus is most often horizontal and of small amplitude and high frequency ("shimmering"). It may be inconstant, vertical or monocular and has, on occasion, been noted to be greater in the abducting eye on lateral gaze. The head nodding is irregular and may increase when the child inspects an object. A familial occurrence has been noted.

Spasmus nutans has been important to the clinician not only because of its occasional appearance on various certification examinations but also because its typical findings and benign course have been claimed to render unnecessary further diagnostic investigation.[4] However, several recent articles have alerted us to the possibility that more serious conditions may be hidden beneath this rare but benign entity. An unrecognized tumor involving the third ventricular region and optic chiasm may originally present to the clinician as spasmus nutans.[1,7-9] The older literature attributed spasmus nutans to a variety of causes including syphilis, rickets, malnutrition, light deprivation of winter ghettos, poor dentition, trauma and epilepsy.[6] Those more familiar with the topic of this issue of *The Journal* will recognize the association between those conditions and the disordered family lifestyle which so often results in child abuse, neglect, and nonorganic failure to thrive. The

purpose of this paper is to present two illustrative cases and to speculate on the association between spasmus nutans and child abuse/neglect.

Case 1. — A 15-month-old black female was noted by a private physician to have head bobbing without nystagmus and was thought to have spasmus nutans. She had been followed intermittently for a small ventricular septal defect which was hemodynamically insignificant. She had received no immunizations and had multiple impetiginous lesions which were treated with Bicillin. She was referred to a neurologist who confirmed presence of mild to moderate developmental delay but did not note nystagmus or head tilt. She was referred to Developmental Services for an infant stimulation program and was scheduled to return in three months. During that interval appointments for evaluations were not kept, nor did she visit her physician. She arrived in the hospital emergency room at 17 months of age because of fever (103.5 F), refusing food and drooling. During the physical examination the mother incidentally mentioned that the baby's leg was swollen. She denied noticing any abnormal head or eye movements and any history of trauma or injury. Physical examination and immediate x-ray investigation revealed four fractures in varying stages of healing including the distal right humerus (acute), proximal right tibia (four to six weeks' duration), and distal left tibia and fibula (less than three weeks' duration). The left ankle was swollen, tender, and unstable. Head nodding and constant pendular nystagmus of both eyes were quite noticeable. In fact the nystagmus was so marked that funduscopic visualization was almost impossible. During a hospital stay of one month further skeletal x-rays, computerized tomographic scan of the brain, and electroencephalogram were all normal. Iron deficiency anemia was found and treated. Group A beta-hemolytic streptococcus was cultured from an aspirate of the ankle and from the blood. She responded to antibiotic therapy and surgical debridement then and during subsequent hospitalization for removal of bony sequestrum. During the hospital stay the 18-year-old mother was delivered of her third child within a three-year period. During the hospital stay, the patient became quite sociable; developmental status and muscular tone improved; head bobbing and nystagmus decreased significantly, and completely resolved during 18 months subsequent follow-up. The mother's live-in boyfriend stated to the investigating team that he was "trying to teach her to walk." He pled no contest to a charge of aggravated child abuse and received a sentence of ten years. The child and her siblings were placed in foster care and currently are about to be returned to the mother.

Case 2. — A 10-month-old black male was brought to the Child Protection Team by the Single Intake Counselor following referral from the local emergency room for failure to thrive. Although he was born prematurely weighing 2½ lbs after seven month gestation, he had done well. He received nutritional supplementation through the Women, Infants and Children's Program until he was lost to follow-up. There was another sibling 20 months of age. The mother was 18 years old and in the midtrimester of her third pregnancy. She denied any recent illnesses and felt that the boy ate fairly well. He was emaciated; the only subcutaneous fat tissue was a buccal fat pad remnant. His weight was 5.12 kg (far felow the 50th percentile, average weight for a two month old), length was 62.5 cm (far below the 3rd percentile for age, 50th percentile for four months of age), and head circumference was 45 cm (normal for age). A pendular lateral nystagmus was present in both eyes but much greater in the left. There was no head nodding but he was quite weak and hypotonic. He had marked head lag and could barely lift his head when placed prone. He did not remove a handkerchief placed loosely over his face. During a three-week hospitalization, he gained 0.83 kg, became socially more responsive and stronger. The nystagmus gradually disappeared. Work-up revealed no organic disease and included a normal computerized tomographic brain x-ray study. He remains in foster care and an infant stimulation program and continues to improve nutritionally and developmentally.

Discussion • In both cases, spasmus nutans was associated with child abuse or neglect. In the first case, spasmus nutans originally presented as head bobbing with little, if any, nystagmus. This resembles the clinical course originally described by Osterberg.[6] Concurrently there were suggestions of a disordered family situation (neglected immunizations, missed well-baby appointments, single impoverished teenage parent with multiple closely spaced pregnancies, recommendation of infant stimulation program for the child) but no obviously abusive or severely neglectful behavior. During the time the child was lost to follow-up, nystagmus developed and she suffered serious injuries. In the second case, there were also several suggestions that the infant was at risk for abuse or neglect (prematurity, teenage impoverished single parent with multiple pregnancies closely spaced, lack of immunizations). During the time when he too was lost to follow-up, he became seriously malnourished and spasmus nutans developed manifested by asymmetrical nystagmus. He was too weak to accomplish any head bobbing or torticollis. In both cases, spasmus nutans cleared spontaneously and has not recurred. In both cases, no underlying intracranial tumor or defect was found. In the second case, there was no physical abuse but the severe malnutrition responded to the provision of adequate calories and emotional support with a weight gain of one ounce per day for three weeks, confirming the diagnosis of nonorganic failure to thrive secondary to caloric malnutrition and maternal deprivation. Nonorganic causes are the most common etiology for failure to thrive and maternal deprivation is the single most common cause.[10]

The association between growth failure and spasmus nutans was noted in the early literature[2] but lost popularity as a number of other possible causes were suggested. Gresty and Halmagyi[11-13] focused their attention on the abnormal head movements using very specialized research equipment. They believed that head shaking was a learned adaptive behavior which assisted vision in the case of what they called spasmus nutans by interrupting the nystagmus. In other forms of what was presumably congenital nystagmus, the nodding compensated for the nystagmus by assuming the pattern of an inverse wave form and required a suppression of the vestibuloocular reflex. However, this explanation would not fit the atypical cases in which there was

asymmetrical nystagmus without apparent head nodding or the typical cases in which the head nodding apparently preceded the nystagmus.

It has been previously suggested that spasmus nutans is a maladaptive behavioral disorder associated with disturbed maternal-child relationship.[14,15] But this has been disputed in the study of Jayalashmi et al[16] which investigated spasmus nutans cases derived from the Collaborative Study on Cerebral Palsy, Mental Retardation and Other Neurologic and Sensory Disorders of Infancy and Childhood established in 1959. Controls were utilized in which the only stated criterion for selection was a lack of nystagmus at the 12 month examination. They found "disturbed maternal/child relationships" in seven of either 46 or 56 controls. Two were described as over-stimulating, four as under-stimulating and one as tense. Meanwhile, three of the 28 cases of spasmus nutans were believed to be abnormal by the examining psychologist. He noted a flat emotional response in three mothers and one was felt to be very depressed. Interestingly, it was noted that the very depressed mother's child failed to thrive at four months of age but had recovered by one year of age. No further details were available.

Dr. C. Henry Kempe, in the 1979 Jacobi Lecture to the Pediatric Section of the American Medical Association, said "if we, 20 years ago, missed flagrant child battering, we now miss many atypical presentations of child abuse and sexual exploitation."[10] He went on to suggest several atypical presentations of child abuse and neglect but did not include spasmus nutans. Indeed a computer search of the world literature through the past decade turned up no single article cross indexed under both spasmus nutans and child abuse. A recent review of the ocular manifestations of child abuse and neglect do not mention spasmus nutans.[17-19]

It seems clear that what is termed "spasmus nutans" by the clinician may encompass a variety of disorders with a diversity of causes. When a child with head nodding and nystagmus, particularly asymmetric, is seen by the clinician a diagnosis of spasmus nutans will be entertained. The thorough clinician will then search also for possible occult tumors of the optic chiasm and third ventricular region. Perhaps our two cases will suggest another possibility — that of the disordered family relationship which may lead to the spectrum of child abuse and neglect. Just as additional specialized radiological studies will be employed to rule out tumor, we suggest that specialized behavioral, psychological and social investigations might be employed to rule out the underlying abusive and neglectful behavior. Just as the unrecognized and untreated tumor may progress to more severe consequences if not attended to, the unrecognized abnormal behavior in the untreated disturbed family may progress from simple neglect to potentially criminally abusive assault.

References

1. Antony, J.N.: Ourvrier, R.A., and Wise, G.: Spasmus Nutans: Mistaken Identity, Arch. Neurol. 37:373-375, 1980.
2. Thomson, J.: Note on Peculiar Nystagmus of Spasmus Nutans in Infants, Br. Med. J. 1:763, 1901.
3. Walsh, F.B. and Hoyt, W.F.: Clinical Neuro-Ophthalmology, ed. 3, Baltimore, The Williams & Wilkins Co., vol. 1, pp. 274-277, 1969.
4. Keltner, J.L.: Neuro-Ophthalmology, Pediat. Ann. 12:597, 1983.
5. Katzman, B.; Lu, L.W., and Tiwari, R.P.: Spasmus Nutans in Identical Twins, Ann. Ophth. 13:1193-1195, 1981.
6. Osterberg, G.: On Spasmus Nutans, Acta Ophth. 15:457-459, 1937.
7. Koenig, S.B.; Naidich, T.P., and Zaparackas, Z.: Optic Glioma Masquerading as Spasmus Nutans, J. Pediat. Ophth. 19:20-24, 1982.
8. Schulman, J.A.; Shults, W.T., and Jones, J.M. Jr.: Monocular Vertical Nystagmus as Initial Sign of Chiasmal Glioma, Am. J. Ophth. 87:87-90, 1979.
9. Lavery, M.A.; O'Neill, J.F.; Chu, F.C., and Martyn, L.J.: Acquired Nystagmus in Early Childhood; Presenting Sign of Intracranial Tumor, Ophthalmology 91:425-435, 1984.
10. Kempe, C.H.: Child Abuse — Pediatrician's Role in Child Advocacy and Preventive Pediatrics, Am. J. Dis. Child 132:255-260, 1978.
11. Gresty, M.A. and Halmagyi, G.M.: Abnormal Head Movements, J. Neurol. Neurosurg. Psychiat. 42:705-714, 1979.
12. Gresty, M.A. and Ell, J.J.: Spasmus Nutans or Congenital Nystagmus? Classification According to Objective Criteria, Br. J. Ophth. 65:510-511, 1981.
13. Gresty, M.A. and Halmagyi, G.M.: Head Nodding Associated with Idiopathic Childhood Nystagmus, Ann. N.E. Acad. Sci. 374:614-618, 1981.
14. Greenberg, N.H.: Origins of Head-Rolling (Spasmus Nutans) During Early Infancy, Psychosom. Med. 26:162, 1964.
15. Fineman, J.A.B.; Kunibolm, P., and Seridan, S.: Spasmus Nutans: Syndrome of Auto-Arousal, J. Am. Acad. Child Psychiat. 10:136, 1971.
16. Jayalashmi, P.: Scott, T.F.McN.; Tucker, S.H., and Schaffer, D.B.: Infantile Nystagmus: Prospective Study of Spasmus Nutans, Congenital Nystagmus, and Unclassified Nystagmus of Infancy, J. Pediat. 77:177-187, 1970.
17. Harley, R.D.: Ocular Manifestations of Child Abuse, J. Pediat. Ophth. 17:5-13, 1980.
18. Gammon, J.A.: Ophthalmic Manifestations of Child Abuse. In Child Abuse and Neglect, Ellerstein, N.S., ed., John Wiley & Sons, New York, 1981.
19. Nelson, L.B. and Parlato, C.J.: Systemic and Ophthalmic Manifestations of Child Abuse, Clin. Ophth. #5:1-11, 1984, Chapter 44.

● Dr. Moorer, Team Medical Director, Child Protection Team, 2420 East Plaza Drive, Tallahassee 32308.

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

Getting ahead in medicine is an uphill climb.



Unless you have a BellSouth Mobility car phone.

Turn drive time into prep time. This year, our car phones are going to be one of the most popular ways for doctors to control high blood pressure—their own.

Because BellSouth Mobility cellular car phones allow doctors to stay in constant touch. To plan ahead. And to have the frustration of the pay-phone routine painlessly removed by allowing you to give your service an immediate buzz when you get beeped on the road.

Advanced service network. Ours is the most advanced phone system on wheels. It's just as easy to use as your office phone. And it's the only one with a state-of-the-art service network behind it. Making sure that your car phone—and your patience—are state-of-the-art. Now, and down the road.

Call BellSouth Mobility toll-free at 1-800-351-3355. And from there, it's all downhill.

BellSouth Mobility

All you need to know about mobile communications.℠

©1985 BellSouth Mobility Inc

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

TWELFTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

July 28 - August 10, 1985

SHERATON BAL HARBOUR HOTEL — BAL HARBOUR FLORIDA

Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for *certification in internal medicine*. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed materials with references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposiums and audiovisual teaching aids will be offered throughout the meeting. This course will end 30 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I
Infectious Diseases
Immunology — Allergy
Genetics — Oncology — Nuclear Medicine
Endocrinology
Gastroenterology — Hepatology
Ophthalmology — Pharmacology — Toxicology — Dermatology — Laboratory
Neurology — Psychiatry — Radiology

Week II
Slide Review and/or Videotape Session
Cardiology

Pulmonary
Critical Care — Hypertension
Acid-Base — Renal

Rheumatology

Hematology

HIGHLIGHTS

- **Audio-Visual Aids**
- **Pictorial Quizzes**
- **Self-Assessment Sessions**
- **Patient Management Problems**
- **88 hours of AMA Category I Credit**
- **Printed Materials**
- **Self-Assessment Questionnaires**
- **Meet the Faculty Sessions**
- **Video Tape Symposiums**

Registration: Entire Course (July 28-August 10) $750* (Before May 31) $800 (After May 31)
Week I (July 28-August 3) $550
Week II (August 4-10) $550

Enrollment must be limited because of extensive faculty / registrant interaction.

Priority will be given to those registering for the entire course.

For registration and information write to: Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101

**Includes tuition, printed materials, self-assessment questionnaires, use of audiovisual aids, library loan of TV tapes, cassette tapes and set of slides.*

General practice in rural Florida: case study of an anomaly

David P. Adams

After the turn of the century, a definite trend emerged toward both urbanization and specialization of the American medical profession. Medical schools were undergoing massive restructuring of curricula in response to the scathing Flexner Report of 1910, a survey which stood as a sad commentary upon the training of American physicians. As medical colleges restructured their programs under the impetus of reform, many schools — deemed "utterly wretched" by Abraham Flexner — either merged with other institutions, revised their curricula, or closed their doors altogether.[1]

Those physicians who graduated from medical schools which survived the Flexner Report by adopting both curriculum and entrance requirements along the Hopkins model generally opted for urban, if not specialized, practice. Not only did larger cities offer wider opportunities for specialization, they also provided greater financial security and professional association. As Table 1 indicates, fewer medical school graduates entered private practice in rural areas, choosing instead the more urbanized and lucrative sections of the country.[2]

The Author
DAVID P. ADAMS
Mr. Adams is a graduate student and a resource faculty in the Medical Humanities Programs, Department of Community Health and Family Medicine, University of Florida, Gainesville.

Despite this trend away from general medicine and smaller population bases, some apparently well-trained physicians did choose to begin practice in rural areas, plagued by poor secondary roads, that were miles from the nearest hospital. One was James H. Kirby, who practiced in Orange, Florida from 1928 until his death in 1974.[3]

Education and training • A graduate of Georgia Medical College, class of 1927, Dr. Kirby — unlike other physicians within his county who served as the sole health care provider for their communities — could boast of having a degree from an accredited medical school. None of his colleagues in similar practice in the county in 1931 could make such a claim. Those who had graduated from accredited medical colleges (Tulane University School of Medicine and Jefferson Medical College of Philadelphia) had done so long before these schools received either Flexner's or the AMA's accreditation. The Jefferson graduate received his degree in 1878.[4]

Indeed few rural areas served by only one physician were as well cared for as Orange. The combination of Dr. Kirby's recent training and youth (he was only 25 when he entered practice) suggests a high level of medical knowledge as well as good health in general when compared with the ages and credentials of other practitioners in the county. By 1931 only 7% of Florida's rural practitioners had graduated from medical school within the past ten years (Table 2).[5]

As "physician and surgeon," James Kirby entered practice in quite a different setting from that of his internship, the Duval County Hospital at Jacksonville. Kirby's community would not have its own clinic, provided by the physician himself, until

Table 1. — Medical College Graduates in Privatre Practice by Size of Community of Practice, 1930, 1935, 1940, and 1945 Classes Throughout the United States.

Size of Community of Practice	Year of Graduation 1930	1935	1940	1945	Percent Change (1930-1954)
Total	2,666	2,640	2,742	3,178	+19.2
500,000 and over	768	675	663	626	+72.0
100,000-499,999	429	549	589	738	+37.3
50,000-99,999	181	255	299	340	+87.8
25,000-49,999	151	246	328	356	+135.8
5,000-25,999	445	483	480	675	+51.7
Under 4,999	682	401	361	438	−35.8
Unknown	10	31	22	5	

Source: H.G. Weiskotten and Marion E. Altenderfer, Trends in Medical Practice, Chicago: Association of Medical Colleges, 1956, p. 23.

the late 1940s. As he discovered upon his first visit to Orange, transportation was very often an ordeal on even the best roadways — his Model T overturned as he was entering town for the first time.[6]

Problems and practice • Faced with meager facilities, not least when making a call to a home lacking electricity, running water or other conveniences, Kirby often "worked by the seat of his pants."

Table 2. — Decade of Graduation from Medical School for Physicians Practicing as Sole Health Care Provider for their Community in Florida in 1931.

Decade of Graduation	Number
1870-1880	5
1881-1890	11
1891-1900	24
1901-1910	37
1911-1920	30
1921-1930	8
Total	115

Source: American Medical Directory, 12th ed., 1931, pp. 405-417.

During the Depression years especially, many patients had no automobile; Dr. Kirby often treated them in their homes. As his wife noted, he "made house calls all the time."[7]

His office schedule was no less hectic and an average day consisted of seeing the first patient at 10:00 a.m., continuing into the afternoon, and then leaving for rounds in a hospital approximately a 45 minute drive south of Orange. All too often he would return to find an emergency case awaiting attention.[8]

With the exception of very serious cases transported to this hospital, Dr. Kirby conducted much of his practice from the first floor of his home for nearly 20 years. Only then did he construct a separate facility. His original office was composed of eight examining rooms (with several specified as "colored") and three waiting rooms, two for "white" and one for "colored." Surgeries, on the other hand, were scheduled weekly so that he might obtain assistance from colleagues in a nearby town of approximately 7,000 people. According to his wife, Dr. Kirby's operating room was well equipped, and he prided himself on never having lost a patient in surgery.[9]

Dr. Kirby could probably not have chosen a poorer time to enter medical practice, particularly in such a rural area. Aside from the devastating effect the Depression had upon rural populations, general practitioners did not fare well either during the 1930s. Fees for many of them became nonexistent; in Dr. Kirby's case, he was often paid vegetables or hams. His wife and son recall that he never insisted upon patients paying — and some did not.[10]

As one 1933 study indicated, families with an income of less than $1,200 and living in rural areas incurred "very little or no expense for medical care." The report added, however:

> This does not indicate that these families were all in a state of abundant health. Many of them had so little money that a physician was not called; few had any dental care; and many had more care than their charges indicate because part of the medical service they received was free.[11]

Recreational time for Dr. Kirby was nearly as scarce as financial gain from his practice. Seldom was his time his own and even a fishing trip with his son was often somewhat less than private. Kirby's rapport with his patients usually meant that he could not go anywhere in Orange unnoticed by at least one of them. Whether walking down the street or quietly fishing with his son, Dr. Kirby's services were in constant demand. His son recalled a fishing outing: as the two were sitting in their boat, a patient pulled alongside to relate an illness.[12]

Day trips out of town were hardly any different. During the fall, Dr. Kirby would occasionally take his family to a nearby town for an afternoon of college football. He was assigned a parking space near the stadium in the event of an emergency. Such incidents were not uncommon and, paged over the public address system, he and his family would leave the unfinished game so that he might attend to the patient.[13]

Late night emergencies proved arduous, if not dangerous at times. Most common were childbirth cases and, on occasion, auto accidents "up the highway." In general, Dr. Kirby attended only the births of white babies, leaving the care of black mothers to local midwives. When complications arose, however, he was often summoned unexpectedly to the bedside of one of his black patients. Poor roads and inadequately fenced pastures made these calls quite dangerous. Once returning from a late night call he accidently struck a cow that had wandered onto the roadway.[14]

Dr. Kirby used a wide variety of drugs. Unlike an older colleague in a neighboring county who was a 1909 graduate of the Atlanta College of Physicians and Surgeons, he kept current on newer pharmaceutical developments. When one compares the prescription files of Dr. Kirby with those of Dr. Smith in Elton, this becomes strikingly clear, particularly in regard to the "wonder drugs" which appeared in the late 1930s and throughout the 1940s. Although Dr. Smith began prescribing sulfanilamide at approximately the same time as Dr. Kirby, the former's prescription files indicate that he never yielded to newer medications (especially penicillin) to any great degree. A review of his prescriptions shows that when he did use newer forms of the sulfas, he consistently misspelled their names. Dr. Kirby, on the other hand, shifted to increased prescription of penicillin as it became more widely available. Even if Dr. Smith had not been keeping abreast of medical advances through JAMA or other journals, he should have been aware of penicillin as a result of the coverage through the popular press.[15]

The initial years of Dr. Kirby's practice forced him to compound and dispense his own drugs; Orange had no pharmacy until the early 1930s. When one considers the many pharmacies that did not survive the Depression years, Dr. Kirby was fortunate to have had the services of a professional pharmacist at all. Without the convenience of brand name drugs, he generally wrote prescriptions that required tedious compounding and measurement.[16]

Despite Dr. Kirby's isolation in Orange, his prescribing practices do not appear very different from those of an urban practitioner. As a 1935 American Pharmaceutical Association survey indicated, aspirin and sodium bromide were numbers two and five respectively as the most commonly prescribed single ingredients. Both substances appear throughout Kirby's prescription files and were often prescribed as a compound. Indeed, sodium bromide appears in nearly 20% of a random sample of his prescriptions. Alone, sodium bromide was used as a sedative; in combination with aspirin Dr. Kirby often prescribed it every four hours "when needed for restlessness or to reduce fever."[17]

Quinine, despite a serious malaria problem in Orange during the middle 1930s, accounted for only around 8% of Dr. Kirby's prescriptions. Most of these appeared during the peak malaria years and then fell of sharply as the disease abated. Although one physician, a graduate of the University of Virginia School of Medicine in 1936, lamented that quinine had been a standard cold remedy for decades, he had been taught to use the drug only for cases of malaria.[18] Such a specific use characterized Dr. Kirby's practice as well. In fact, his prescriptions for quinine exhibit an almost textbook quality; judging from the admonitions of Cecil's Textbook of Medicine (1930 edition) Dr. Kirby's dosages were letter perfect.[19]

By the late 1930s, Marshall Taylor and his associates reported that quinine could cause hearing impairment and appear in the blood specimens of newborns as well. If, as Dr. Kirby's family pointed out, the Orange physician was eager to keep current on the latest medical developments, he probably knew of Taylor's work firsthand; he was an active participant in both local and state medical societies.[20]

Anomaly of modern medicine • Dr. Kirby was quickly becoming an anomaly of modern medicine by 1930. General practice had become far less attractive to young physicians and rural areas failed to attract new practitioners to take the places of those who were dying off. Although Dr. Kirby was 25 when

he began practice in Orange, his colleagues, who were also the sole health care providers in other communities around the county, averaged nearly 60 years of of age. As Table 3 shows, however, the mean age of physicians in urban areas around the state was considerably lower. In a nearby community of over 7,000, the mean age of all physicians in 1931 was only around 48.[21]

The older practitioners in rural areas were not being replaced. As was the case with Orange, the community physician simply practiced until incapacitated by illness or death. Dr. Kirby himself replaced the recently deceased town doctor. During this era "The Physician's Business," a manual dealing with the practical economics of medical practice, suggested that rural medicine could prove a very positive experience:

> The inducements offered are that expenses are at a minimum, and collections better than in the city, where the population is do largely shifting. If these advantages outweigh the allure of the city in the eyes of the young doctor, he will do well to equip himself with a good road map, listing towns and their populations. With a little luck, one might even find a town that had been "left doctorless."[22]

Since Dr. Kirby's death in 1974, Orange has been left essentially without medical care of its own. When a physician's services are needed the individuals are forced to travel to a nearby community, usually a round trip of at least an hour. Those few physicians who have attempted to practice in Orange since 1974 have not remained for an extended period. Today, although the pharmacy serves the community, local medical care is available only two days a week.

One can only speculate about Orange's relative lack of local health care. Certainly, general practice in such a community, as Dr. Kirby's experiences indicate, would often prove demanding and would leave little room for private life. Financial concerns might also be a major factor. The expense of medical school (and possible loan debts upon graduation) might well entice a graduate to seek the most lucrative practice available. Orange would hardly be an optimal setting for great financial gain. One wonders, however, if the predicted glut of physicians will induce some to seek locations in the less competitive medical markets rather than major urban centers.

Table 3. — Mean Age of Physicians in Florida Communities Over 10,000 persons, 1931.

City	Population	Mean Age
Sanford	10,100	46
Tallahassee	10,700	46
Key West	12,831	49
Daytona Beach	16,598	48
Lakeland	18,554	47
West Palm Beach	26,610	53
Orlando	27,330	42
Pensacola	31,579	45
St. Petersburg	40,425	52
Tampa	101,161	51
Miami	110,637	43
Jacksonville	129,549	48

Source: American Medical Directory, 12th ed., 1931, pp. 405-417.

References

1. Stevens, R.: American Medicine and the Public Interest, New Haven; Yale University Press, 1971, pp. 67-68; see also, Starr, P.: Social Transformation of American Medicine, New York, Basic Books, 1982, pp. 118-123.
2. Weiskotten, H.G., and Altenderfer, M.E.: Trends in Medical Practice, Association of American Medical Colleges; Chicago, 1956, p. 23.
3. James H. Kirby, M.D., and Orange, Florida are pseudonyms for an actual physician and community. Their true identities have been omitted in order to protect the anonymity of family members and the community upon which this study is based. "Rural" is defined as communities with less that 1,000 persons and "sole health care provider" as the only physician listed for a particularly rural community, based on the listing in the American Medical Directory, 12th ed., 1931.
4. American Medical Directory, 12th ed., American Medical Association, 1931, pp. 405-417.
5. Ibid.
6. The following description of Dr. Kirby's practice is taken from a personal interview with his family, July 2, 1984.
7. Ibid.
8. Ibid.
9. Ibid.
10. Ibid; Stevens, American Medicine and the Public Interest, pp. 176-177.
11. Reed, L.D.: Ability to Pay for Medical Care, Publications of the Committee on the Costs of Medical Care, No. 25, Chicago. University of Chicago Press, 1933, pp. 66-67.
12. Kirby Family, personal interview.
13. Ibid.
14. Ibid.
15. Dr. Smith and Elton, are pseudonyms for an actual physician and Florida community in which he practiced. Their true identities have been omitted in order to protect the anonymity of the family members and community upon which this study is based. The data on the prescribing practices of both Dr. Smith and Dr. Kirby are based upon the prescription files from the "Orange" and "Elton" pharmacies. The former are in the personal files of David P. Adams, Department of History, University of Florida, Gainesville; the latter are in the possession of Alvin Hendrix. The author wishes to thank Mr. Hendrix and Grady Smith for their kind assistance on obtaining the prescription files of Drs. Kirby and Smith. For a recent treatment of penicillin's image in popular press, see David P. Adams, "The Penicillin Mystique and the Popular Press (1935-1950)," Pharmacy in History 26 (1984), pp. 134-141. See also, David P. Adams, "Penicillin and American Civilian Compliance: 1943-1945," unpublished seminar paper, Washington University in St. Louis, 1982.
16. Kirby family, personal interview; prescription files of "Orange" Pharmacy. The conclusions concerning Dr. Kirby's prescribing practices are based on a random sample of 370 prescriptions written by him between 1933 and 1947. See also Lillian H. Bowen, N.A.B.P. Statistical Survey: National Survey and Analysis by State, Chicago: National Association of Boards of Pharmacy, 1936.

17. Delgado, F.A.: Professional Pharmacy: An Analysis of Prescription Department Activities, 2nd ed., Washington, D.C., American Pharmaceutical Association, 1935, pp. 65-69; prescription number 12584, filled September 18, 1936, "Orange" pharmacy. The author would like to acknowledge the assistance of Herbert Lewitt, pharmacist, Panama Drugs, Jacksonville, Fl., for his help in analyzing the prescriptions in the "Orange" files.
18. "Orange" files; personal interview with Frederick Bowen, M.D., Jacksonville, April 30, 1984.
19. Cecil, R.L.: A Textbook of Medicine, 2nd ed, Philadelphia: W.B. Saunders, 1930, pp. 395-396
20. Kirby family, personal interview. For Taylor's early work, see especially, H. Marshall Taylor, "Impaired Hearing from Certain Drugs and Chemical Poisons," J. Fla. M. A., January 1938, 377-383; H. Marshall Taylor, Lucien Y. Dyrenforth, and Cash B. Pollard, "Absorption of Quinine into the Cerebrospinal Fluid of the Fetus Utero, "J. Fla. M. A., April 1941, 487-491. The latter also appears in Ann. Oto. Rhin. Laryn., December 1941, 1030-1037.
21. American Medical Directory, 12th ed., 1931, pp. 405-417.
22. Wolf, G.D.: Physician's Business: Practical and Economic Aspects of Medicine, Philadelphia, J.B. Lippincott, 1938, pp. 30-31.

Acknowledgments

The author would like to thank Dr. Lee Crandall for his helpful comments and the Department of Community Health and Family Medicine, University of Florida College of Medicine, for its assistance in preparation of the manuscript.

● Mr. Adams, University of Florida, Department of History, 4131 GPA, Gainesville 32611.

Academic radiology: can it survive?

Juan V. Fayos, M.D.

We are entering an era of intense competition in medical care. It is difficult to estimate the impact of this development, particularly for medical schools and teaching institutions that care for a large segment of the poor or near poor population. It is even more difficult to estimate the impact that such competition will have on the separate departments that are part of such large institutions.

Traditionally, medical school revenues have come from a broad spectrum of sources: tuition, state and federal support, private philanthropy, patient care fees and research grant support, generally from the Federal Government. In recent years, however, this broad support to educational institutions has changed substantially.[1,2] Cessation of capitation grants, decreases in both philanthropy and research support from all sources, including the Federal Government, have had effects on medical school budgets. To make matters worse, all these changes have occurred at a time of increasing costs.

The high increase in medical cost has resulted in legislative changes aimed at reducing payments. The most recent one will reimburse hospitals with payments based on the average cost of hospitalization in nine regions of the country: the Diagnostic Related Groups (DRG) for Medicare patients. This presumably will nurture efficiency and competition, but might have an adverse effect on teaching institutions. In addition, the development of other prospective payment plans, competitive bidding for physician and hospital services, etc. could have also unforseeable consequences for academic institutions.

A medical school is obviously a complex institution with a variety of goals. Its faculty not only has to deliver a sound theoretical basis to students, but also has to provide patients for its students to teach them the "art and science" of medicine. In large schools, it becomes imperative that a sufficient number of patients be available to fulfill this function. For example, the University of Miami (UM), as well as other medical schools, has developed affiliations with other hospitals. The UM's main affiliation is with Jackson Memorial Hospital (JMH), a hospital partially supported by Dade County to care also for the indigent patient. This association permits the medical school to have a large patient body that satisfies its educational goal. The faculty is responsible at JMH for teaching residents in the hospital program, supervising the care rendered to patients, and administrating the medical services of the hospital. As a consequence of this association, high quality medical services, from primary to tertiary care, are given to the paying as well as to the nonpaying patient.

In an effort to fulfill their education mission while at the same time creating a broader financial base, most medical schools, including the University of Miami, have developed medical service plans.[3] These plans collect the professional component of the medical cost, most often reimbursed by a third-party on a fee-for-service basis. Consequently, the medical faculty is increasingly competing against

The Author
Juan V. Fayos, M.D.
Dr. Fayos is Professor of Radiology, Director, Division of Radiation Therapy, University of Miami School of Medicine, Jackson Memorial Hospital, Miami.

the community physicians for the paying patient in an effort to increase revenues.

To determine the current viability and future expectations of a large academic department, a financial analysis of the Department of Radiology at the University of Miami School of Medicine was conducted. Revenues, expenditures and constraints in the delivery of radiological services were analyzed.

Financial Status of Radiology — Revenues • In the fiscal year 1981-1982, the main revenues for our department came from patients' services (67%), reflecting the increasing dependence of this source of revenue upon the financial survival of the department. Next came fixed support from Jackson Memorial Hospital (26%), and the UM School of Medicine (6.6%). Gifts and research contracts from the Federal Government contributed a meager 0.4%. Of a total gross revenue of $7.9 million generated in fiscal year 1981-1982, one third, or $2.6 million, was actually collected. This is due to the large number of indigent, refugees, and near poor people who received radiological services but were unable to pay for them. In the fiscal year 1981-1982, the department did not receive any payments for almost $2.5 million of services rendered to the indigent/refugee population of Dade County. Poor or near-poor patients unable to qualify for any entitlement programs were not included in the above figure.

Medicare contributed 35.6% of all net revenues for the fiscal year 1981-1982 and yet they constituted 10.6% of gross revenues. These figures display the paramount importance of this program in the fiscal stability of our academic department. Medicaid patients generated 20.6% of our gross revenue ($1.6 thousand) for the year 1981-1982 and produced 17.3% of the net income ($0.46 million). In short, payments from Medicaid were 28.5 cents to the dollar for the fiscal year 1981-1982, a substantial discount and one of the reasons why many private practitioners do not accept this type of patient. Even though the amounts paid by Medicaid are heavily discounted, the importance of the program on the financial solidity of a department such as ours cannot be underestimated. If Medicaid did not exist, this revenue would have to be written off completely as are the gross revenues from indigent and refugee patients.

Expenditures • The largest expenditure is for faculty salaries and fringe benefits, which constituted 78.1% of all expenditures ($2.8 million) in fiscal year 1980-1981. Salaries paid to the faculty averaged about $75,000 a year. They are below the 50 percentile of the average salaries paid to physicians in academic medicine throughout the country and below those paid in the private sector. The median net salary for private practice radiologists who work primarily in hospitals is $127,310.[4]

Administrative and billing expenses were the second largest expenditure, 11.6% ($0.5 million). Next came a medical school "tax" with 7.2% of expenses or $0.3 million. The department contribution to the medical school was higher than the contribution of the medical school to Radiology. In effect Radiology financially subsidizes the medical school and absorbs the cost of teaching students and residents. No significant allocation was given to clinical research or purchase of equipment for research purposes, perhaps the gravest deficiency of our department.

Discussion • As a result of increases in expenditures and the low collection ratio of our department (Diagnostic and Therapeutic Radiology and Nuclear Medicine) due to the large burden of nonpaying patients, an annual deficit has occurred consistently since fiscal year 1978, in spite of revenue shifting from one division to the other.

If academic departments cannot entirely subsidize the medical care of the poor or near poor while fulfilling their primary functions of teaching and research because of financial constrains, what are the options available?

The most common action taken to solve budget deficits is to increase the price of each procedure. We have followed this dictum and have increased our prices steadily. In fiscal year 1981-1982, the increase was 17% on the average price of each procedure. This increase has permitted certain fiscal solvency, but it has shifted significantly costs to the paying patients in an effort to subsidize our nonpaying ones. However, in view of increased competition and federal government actions to arrest price increases, it is unlikely that this mechanism will be maintained for long. The prices for services rendered by UM will be so out of line with competing radiological services that a further drop in the number of paying patients will occur as we price ourselves out of the radiological market.

An action to correct financial deficits is to cut down expenditures. In Radiology, the largest expenditure is the payment of faculty salaries and fringe benefits. Consequently, elimination of the number of physicians necessary to balance the budget would appear to offer a solution, provided that a commensurate reduction in the services to those patients who do not pay were carried out. While this solution is feasible for certain industries, such as automobile, manufacturing, etc., it is not feasible for public health institutions, which have to provide care for the very poor who have no access to other facilities. Therefore, reducing the number of physicians and

their corresponding services is not a solution, but would add to the problem of providing medical services to the poor.

Another device to reduce cost is labor substitution from an expensive producer to a less expensive one. It is possible that certain radiological procedures could be done by individuals less qualified than a radiologist. For example, an x-ray technologist or a medical student could read, unsupervised, all chest x-rays on indigent patients or a nurse could administer radiotherapy to certain patients with malignant tumors. These are options that, although feasible, are not bound to occur. They will be equivalent to the creation of a multi-level system of medical care, one for the poor and a better one for the paying patient, a condition that society, government, and physicians reject at the present time. Commitment to medical care of equal quality for all is presently an important societal goal.

Since nonpaying patients pose the greatest financial problems to institutions such as ours, one obvious solution would be to support legislation inducive to a national health insurance system. If everyone paid for services rendered, be it on a fee-for-service or prospective basis, the distribution of the nonpaying patients in a community to a single health facility would disappear. However, the present political climate in Congress is contrary to this development due to the expected high cost of the program.

It is evident that academic medicine cannot continue to cover costs from teaching and research activities out of patients' revenues as in the past and particularly in those institutions facing a high load of nonpaying patients as in our case.

Consequently, in order to fulfill the objectives of academic institutions towards education (graduate and post-graduate), research and service to patients, the present financial arrangement must be altered.

One solution would be to give grants for clinical research and teaching to medical schools and teaching hospitals from the federal or state governments financed out of general revenues. The likelihood of this solution is poor indeed, particularly in this era of tight budgets.

Another solution would be to allocate a portion of the health care bill contributed by the government (Medicare, Medicaid), third party carriers, etc. to a special fund for teaching, education and research. Different schemes to support teaching and clinical research have been suggested, including the creation of a national fund for teaching hospitals (5). However, such a national fund would be burdensome to administer and subjected to a great deal of political pressures which may lead to a larger distribution of benefits to certain regions or institutions at the expense of others.

Conversely, a state fund might be the proper mechanism for a teaching and research fund for medical use. Each state could tax health insurance carriers and other health providers to generate the necessary funds to support as much research and teaching as each state would desire. In this fashion, all of the participants in the health industry would contribute to education and clinical research, rather than the few institutions that at present are doing it on a cost-shifting basis.

If institutions such as ours were to be paid for teaching and clinical research from dedicated funds such as that described above, they will be in better position to compete with other health provider organizations while delivering medical care of excellent quality to a segment of the poor in our society. However, if no substantial financial changes are made in the way we finance our teaching institutions, they are certainly headed towards rough times with unavoidable decay of their missions.

Summary •The main problems facing teaching institutions affiliated with hospitals that accept a large load of indigent patients are a) the delivery of medical services not being paid for, and b) the lack of appropriate financial support for teaching and clinical research functions.

As we enter an uncertain stage in the financing of medical care with a movement towards pluralistic concepts of payment, including HMO's, prospective payments, fee-for-service, etc., academic institutions and their corresponding departments might suffer substantially in their mission unless changes in financing their different activities are found. One solution to problems in academic medicine might lie in the creation of a state fund earmarked for teaching and clinical research financed by the health insurance industry and government. This fund will support teaching and clinical research, thus freeing academic institutions and the paying patients of the enormous burden of cross-subsidizing education and research out of clinical service activities. If funds earmarked for teaching and research were to come separately to academic institutions, they should be able to compete in an open market for patients' services on an equal basis, while still providing a large amount of care for the nonpaying patient.

References

1. Cluff, L.E.: Medical Schools, Clinical Faculty, and Community Physicians. Special Communications — JAMA, 1982, 247:200-202.
2. Inglehart, J.K.: Shrinking Federal Support Brings New Era to Education in the Health Professions. Health Policy Report — The New England Journal of Medicine, 1981; 305:1027-1032.
3. Schmidt, C.W., Jr.; Zieve, P.D.; D'Lugoff, B.C.: A Practice Plan in a Municipal Teaching Hospital; A Model for the Funding of Clinical Faculty. Special Article — The New England Journal of Medicine, 1981; 304:263-269.
4. Holoweiko, M.: Those Hospital Specialties: Alive and Very Healthy. Medical Economics, March 7, 1983,pp. 148-171.

5. Colloton, J.W.: Competition: The Threat to Teaching Hospitals. In Financing Health Care: Competition versus Regulation. The Papers and Proceedings of the Sixth Private Sector Conference. Edited by Duncan Yaggy, Ph.D. and William G. Anlyan, M.D. Ballinger Publishing Co., Cambridge, Mass., 1982, pp. 131-228.

● Dr. Fayos, University of Miami School of Medicine, Division of Radiation Therapy (D-31), P.O. Box 016960, Miami 33101.

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 M D

Your Avis AWD Number:
A/A 616900

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

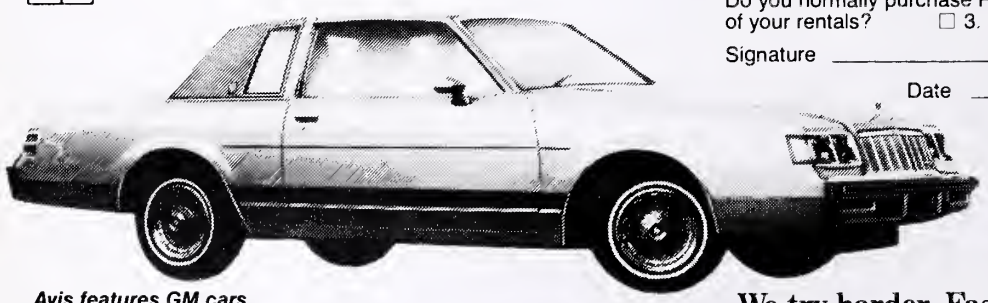
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ; LaGuardia Airport, NY; JFK Airport, NY and all Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

1985 Avis Rent A Car System, Inc. Avis®

3/85 Printed in U.S.A.

New Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

Upjohn

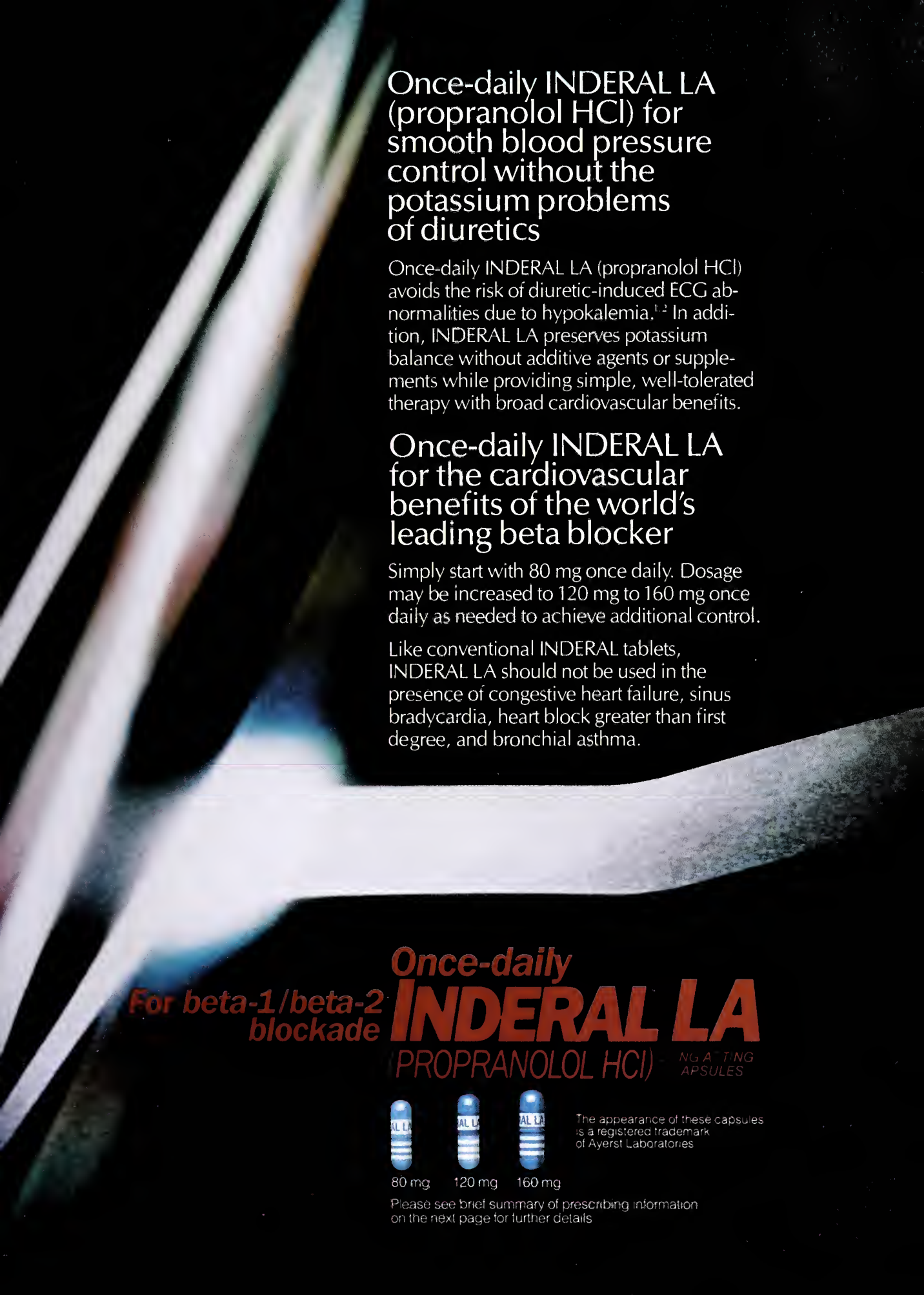
The Upjohn Company
Kalamazoo, Michigan 49001 USA

©1985 The Upjohn Company

J-5491 June 1985

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories

Please see brief summary of prescribing information on the next page for further details

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

9411/1184

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

The Health Maintenance Organization as a cost containment instrument: logic or illusion?

The Health Maintenance Organization (HMO) movement is enjoying a mighty resurrection.

An infusion of $464 million dollars of federal grants and loans which began with the Nixon administration catapulted the concept into its logarithmic growth phase and launched 150 HMOs during the 1970s. Then the pace of growth turned sluggish as enrollment suffered, financial problems arose, and 27 HMOs failed. The public cry for cost containment over the last 4 years, however, has revived HMOs and has transformed them into a highly vital, competitive force in the health care delivery system. Nearly 17 million people were enrolled in 337 HMOs by the end of 1984 — a 22% increase over 1983. Fifty-four additional HMOs became operational during the first three months of 1985. Florida now has 19 HMOs and had nearly 520,000 members at the end of 1984 — a 55.5% increase over 1983 and the largest percentage increase in the nation. By 1987, Florida is projected to have nearly 2 million enrollees and the nation is projected to have over 25 million HMO enrollees. The preponderance of HMO activity is concentrated in urban areas with populations greater than 500,000 people.

The political attraction of the HMO resides in the performance by the HMO of dual roles as both insurer and provider. Thus, the HMO assumes the financial risk for providing all medical care for the population it enlists. The assumption is that, by accepting financial risk, the cost of care will decrease. This assumption has yet to be certified as legitimate.

Three major types of HMOs exist. The first is the staff model which is a corporate structure that usually owns its own facility and hires physicians as employees. The corporation assumes the financial risk for any losses. The most common type is the group practice model in which the group contracts its services to the HMO and divides the risk for care among the partnership. The third model is the Independent Practice Association (IPA) in which individual private doctors or small groups operating out of their offices contract for care of patients. Fee-for-service payment is frequently, but not always, used in the IPA model. The individual doctors share any losses of the IPA.

What is the evidence that HMOs provide effective mechanisms for health care cost containment? ● The most extensive study of the cost containment benefits derived from HMOs was conducted by the Rand Corporation from 1976 to 1981.[1] The 1,580 patients included in the study were randomly assigned to 6 health care delivery groups. Group One patients received care on a fee-for-service basis. All care, both inpatient and outpatient, was provided for free. Participants in Groups Two, Three and Four also used fee-for-service physicians but these patients were required to co-insure (i.e., they had to pay part of their total health care bill). Group Two patients paid 25% of their annual inpatient and outpatient costs up to a maximum of $1,000 per family per year. Group Three patients paid 95% of the same costs with the same $1,000 limitation per family per year. Group Four patients paid 95% of their outpatient bills only up to $150 per person or $450 per family per year. Inpatient costs were totally covered. Groups Five and Six were enrolled in the Group Health Cooperative of Puget Sound (GHC) in Seattle, Washington. Group Five patients were new enrollees in the plan; Group Six patients were a random sample of GHC members in 1976. GHC is a pre-paid HMO in which all inpatient and outpatient services are provided by the annual enrollment fee.

The study results demonstrated the following: First, fee-for-service physicians use in-hospital patient care significantly more than do HMO doctors. The greatest differences existed in the patients in Group One who had all medical costs covered. In this group there were 83 hospital days per 100 persons versus 49 hospital days per 100 persons in Group Five (HMO group). Surprisingly, the lowest hospital utilization was in patients in Group Four, i.e., those who had to cover most of their outpatient costs but who had free inpatient care (28 hospital days per 100 persons). The second conclusion was that outpatient visits per person per year were slightly less for fee-for-service than for HMO physicians. Third, the imputed costs per patient per year varied significantly from $609 per participant in Group One (the free fee-for-service group who received all their care for free), to $413 per participant per year in the fee-for-service Group Four who had to pay 95% of their outpatient bills up to $150/person or $450/family per year. The HMO Groups, Five and Six, incurred an annual expense of $439 and $469 respectively per participant per year — less than in the first 3 fee-for-service groups.

The heuristic principles derived from this study are that cost containment can be accomplished with either reduction of hospital usage or by making the patient bear a major share of the outpatient cost risk. It demonstrates that the major cost containment mechanism of HMO doctors is a lower rate of hospitalization utilization. The number of outpatient visits is the same or slightly higher in pre-paid HMO groups. These findings are similar to those derived from a previous review of HMOs in 1978.[2]

There is one major difficulty with the Rand study — the patient selection. Excluded from the study were certain economically high-risk groups such as patients over the age of 62, those eligible for Medicare disability, those on end-stage renal dialysis programs, and those who were institutionalized. Such individuals consume a huge fraction of the American health dollar, and their exclusion from the study may taint the conclusions.

Luft reviewed the pre-1978 literature concerning the economics of HMO savings.[2] He also concluded that the total medical care costs are lower for HMO participants than for fee-for-service medical care. The cost savings flowed from lower rates of "discretionary" surgery and lower rate of medical admissions to hospital, but did not come from shorter hospital stays or from fewer outpatient visits. He could define no other attributes that made HMOs more efficient than standard insurance plans.

Do HMOs offer any other savings besides cost of hospitalization — such as lower use diagnostic services • These data are not available, but an approximate answer to this question was attempted by a study reported by Hlatsky et al.[3] Case summaries from 51 patients with chest pain were submitted to 91 cardiologists drawn from private fee-for-service practitioners, HMO physicians, and academic faculty members in the San Francisco-Oakland metropolitan area. Each physician was asked whether exercise thallium scintigraphy (a procedure costing about $600) and/or coronary angiography (a procedure costing about $3,000) were indicated in each patient. It was found that the HMO cardiologists recommended each procedure significantly less frequently than did private practice doctors. Academic physicians were intermediate between the HMO and private practice physicians. Outcomes — such as death, myocardial infarction, etc. — obviously could not be measured by the study design. Perhaps HMO physicians use costly diagnostic procedures less frequently than fee-for-service doctors. We have no way of determining if this is advantageous to the patient but the study does reveal a more frugal mind set for HMO physicians.

The quintessential issue in health care economics is, "What is the relationship between cost of care and patient medical outcome and/or economic benefit?" This issue has not been measured in any study.

One limited attempt to correlate medical outcome with payment mechanism was conducted in the Indian Health Service.[4] This study evaluated the performance of 11 medical care entities (2 HMOs, 3 fee-for-service private practices, and 6 government-financed Indian Health Service units) for the management of a very limited number of conditions: prenatal surveillance and counseling, infant immunization and well-baby management, treatment and followup of anemia and urinary tract infection, and screening for hypertension. The results showed that the size of the medical care organization correlated negatively with the quality of treatment and followup care. The payment mechanism showed no relationship to screening, treatment or preventive performance.

Do HMOs lower employers' costs of providing health care benefits? • Probably not. Iglehart[5] reported that Honeywell has calculated that the high rate of employee enrollment in HMOs in the Minneapolis-St. Paul area has cost the corporation millions because the monthly HMO bill must be paid whether or not the employee uses medical services. Honeywell's healthier employees enroll in HMOs; its less healthy elect self-insurance plans, and Honeywell must cover bills generated by both types of insurance. A very recent Louis Harris and Associates survey sponsored by the Kaiser Foundation[6] reports that 30% of executives feel that HMOs decrease employee benefit costs, 51% feel that HMOs have no effect on benefit costs, and 4% feel that

HMOs have increased benefit costs. A synthesis of these reports seems to indicate that subscription to HMO plans does not benefit the employer who provides the health care costs for his employees.

The Honeywell experience and the Rand study quoted earlier identify another problem associated with evaluations of the economic benefits of HMOs, i.e., the possible drift of low utilizers of health care into HMOs. A study reported by Jackson-Beeck et al. in *JAMA*[7] seems to confirm that HMOs attract people who consume fewer health care resources. High-use health care consumers seem to prefer specialists who frequently are unavailable to HMO patients. Certain high-risk patient groups such as the Medicare beneficiaries were excluded from HMOs until the last 18 months. Medicaid patients have been enrolled by only 20% of HMOs and Medicaid patients still comprise only 2% of the HMO population versus 10% of the general population. HMO experience indicates that the hospital admission rate for Medicaid patients is more than 50% greater than for the typical HMO patient, and total in-hospital days is 325% greater. Furthermore, more than half of Medicaid patients leave the HMO after 1 or 2 years of enrollment. Those who leave in the first year consume 550% more hospital services than the typical HMO enrollee! Obviously, exclusion of such high-risk people from enrollment grants HMOs an economic advantage that other providers who care for such individuals lack. As the Medicare-aged population enters HMOs, the cost advantage currently enjoyed by HMOs may rapidly evaporate.

One recurrent criticism against HMOs is that they achieve cost savings by offering low-grade care. The literature disputes this criticism[8,9] but the majority of studies concern populations in which most people are healthy except for transient illness. One recent study[10] which compared the management of rheumatoid arthritic patients by private rheumatologists and Kaiser rheumatologists in the Northern California area, revealed no differences between the two doctor groups in terms of hospital days, frequency of surgery, gold shots, arthrocentesis, or utilization of X-ray and laboratory services. Unfortunately, patient outcomes were not measured. This study failed to show any financial advantage of the HMO over the fee-for-service provider and suggested that Northern California HMO specialists treat chronic diseases such as rheumatoid arthritis with the same intensity as private physicians. Whether the same quality of specialists is available to all HMOs throughout the nation as exists in Northern California is another unknown.

Do HMOs succeed in resisting the inflationary cost spiral? • By limiting in-hospital costs, HMOs frequently offer lower initial rates for health care (currently about $200 per month per family nationwide) than other insurors. They have not been able to resist the effects of inflation, however, and their annual rate increases closely resemble those of other health insurance programs.

How should the individual physician confront the HMO concept? Should he or she ignore it, reject it, or join it? • The following answers are a composite which has been formulated from discussions with a sampling of private practice leaders in Minneapolis-St. Paul and California.

HMOs will survive and co-exist as a health care delivery system within a pluralistic medical care society. They will not displace fee-for-service private practice. If a physician practices in a large urban area, wisdom dictates the consideration of joining one or more HMOs. Younger physicians, who are discovering that starting practices are difficult in popular urban areas, might consider joining a staff model HMO. Reimbursement levels, however, are often low for such physicians. In the Twin Cities area, some HMOs offer an initial salary for family physicians in the $35,000 to $40,000 range. Older, well-established physicians do not experience the same coercion to join as do the younger physicians with limited patient followings. HMOs do increase a doctor's referral base — in contrast, Preferred Provider Organizations rarely expand a physician's practice. Those certain physicians who may be philosophically opposed to HMOs should recognize that HMOs are not inherently wicked or unethical. Furthermore, veneration by books of history or one's colleagues cannot be gained by financial martyrdom. A physician situated in a major urban area, therefore, should consider joining an HMO providing it can increase his present patient population or prevent him from losing a significant portion of his patients.

When enlisting in an HMO, remember that Independent Practice Associations (IPAs) make the individual physician responsible for economic losses. Economic risk is nil for staff model HMOs but can be real in the group or IPA models. Most HMOs are NOT making money; 60% of all federally-qualified HMOs failed to show a cumulative operating surplus over the past 3 years. Furthermore, risk is not limited merely to underestimating health care usage and the rate structure. Malpractice risk can also be substantial; e.g., the malpractice suit rate against certain Kaiser HMO organizations is substantially higher than the rate against fee-for-service practitioners in the same locales. Prior to signing a contract with an HMO or Preferred Provider Organization (PPO), you should obtain from the American Medical Association and read their booklet, "A Physician's Guide for Preferred Provider Organizations," which contains a list of caveats; check this list against the fine print of any contract.

Most doctors in smaller or rural communities do not yet feel compelled to join an HMO, but the current reprieve is probably temporary.

In summary, HMOs do reduce health care expenses for their enrollees by reducing hospital utilization. There is no evidence that they reduce the cost of outpatient care. The cost savings differential between HMOs and traditional health insurance schemes will narrow significantly within the next few years because of convergence of rates of hospital utilization and because of the intense competition for the insurance dollar. HMOs, however, are not the answer to the health care cost problems of this country. They do not answer the problems of the high cost for the elderly or for the terminally ill or for the chronically ill or for the medically indigent, since HMOs do not serve these people. The costs and fees for those dedicated to the care of EVERYONE will necessarily be higher than that of HMOs, whose primary patient population consists of the medically well-manicured.

References

1. Manning, W.G.; Leibowitz, A.; Goldberg, G.A., et al: A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services. N. Engl. J. M. 310(23): 1505-1510, 1984.
2. Luft, H.S.: How Do Health-Maintenance Organizations Achieve their "Savings"? N. Engl. J. M. 298(24):1336-1343, 1978.
3. Hlatky, M.A.; Lee, K.L.; Botvinick, E.H. et. al: Diagnostic Test Use in Different Practice Settings. A Controlled Comparison. ARch. Intern. Med. 143:1886-1889, 1983.
4. Nutting, P.A.; Burkhalter, B.R.; Dietrick, D.L., et al.: Relationship of Size and Payment Mechanism to System Performance in 11 Medical Care Systems. Medical Care XX(7):676-690, 1982.
5. Iglehart, J.K.: Health Policy Report. The Twin Cities' Medical Marketplace. N. Engl. J. M. 311(5):343-348, 1984.
6. Health Market Survey 2(10):1-8, May 30, 1985.
7. Jackson-Beeck, M.; Kleinman, J.H.: Evidence for Self-Selection among Health Maintenance Organization Enrollees. JAMA 250:2826-2829, 1982.
8. Cunningham, F. and Williamson, J.: How Does the Quality of Health Care in HMOs Compare to that in Other Settings? Group Health J. 1:4-25, 1980.
9. Luft, H.S.: Health Maintenance Organizations: Dimensions of Performance. New York: Wiley-Interscience, 1981.
10. Yelin, E.H.; Henke, C.J.; Kramer, J.S., et al.: A Comparison of the Treatment of Rheumatoid Arthritis in Health Maintenance Organizations and Fee-For-Service Practices. N. Engl. J. M. 312(15):962-967, 1985.

Jacques R. Caldwell, M.D.
Daytona Beach

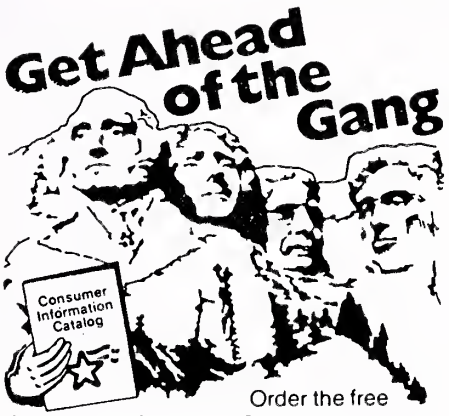
GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad
in the

*Journal of the
Florida
Medical Association, Inc.*

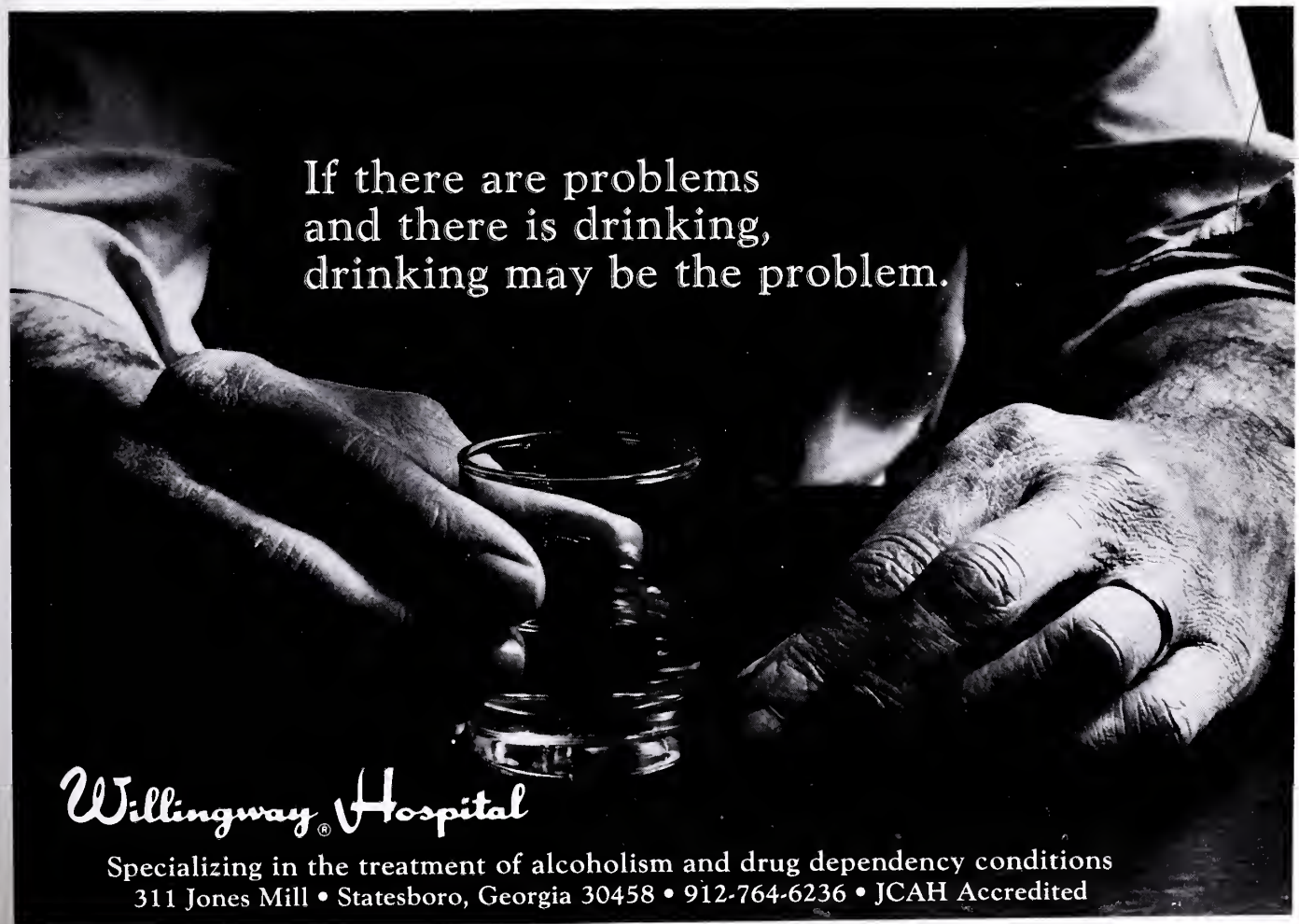
Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571



Order the free Consumer Information Catalog to be on top of the latest government information on credit, health, home, money matters, and much more. It lists more than 200 booklets, many free. So send for the Catalog now. You'll be head and shoulders above the crowd. Write:

**Consumer Information Center
Dept. MR, Pueblo, Colorado 81009**



The AMA Announces...

20 NEW PATIENT MEDICATION INSTRUCTION SHEETS

Now there are 60 PMIs available to help educate your patients about the drugs you prescribe for them

Your patients want to know!
Your patients need to know!
Now you can contribute to better patient education by distributing PMI sheets. PMIs are handy, tear-off drug information sheets that are meant to supplement your verbal instructions to your patients.

PMIs help to improve compliance, strengthen your relationship with your patients, and reduce the number —but enhance the importance— of the call backs you receive.

Quick, simple, balanced drug information
PMIs contain scientifically sound information regarding the drugs you most frequently prescribe. To prevent confusion, particular care has been taken to make PMIs easy-to-understand and easy-to-read. To avoid needlessly alarming the patient, PMIs do not list all adverse drug reactions or less well-documented and rare reactions.

Benefits you and your patients
It is the proper and vital role of the physician to provide drug use information to patients. While face-to-face counseling is an indispensable part of patient education, counseling supplemented by written information has been shown to be the most effective.

PMIs help to improve patient compliance, strengthen your professional relationship with your patients, and reduce the number—but enhance the importance—of the call backs you receive.

ORDER YOUR PMIs TODAY!

Complete this order form and mail it with your payment to:

PMI Order Dept.
American Medical Association
P.O. Box 8052
Rolling Meadows, IL 60008

(Please print)

Name _____

Address _____

City _____

State/Zip _____

Number of pads	PMI Number and Title
_____	027 Allopurinol
_____	018 Belladonna Alkaloids and Barbiturates
_____	012 Benzodiazepines
_____	004 Beta-Blockers
_____	009 Cephalosporins—Oral
_____	032 Chloramphenicol—Oral
_____	017 Cimetidine
_____	031 Clindamycin/Lincomycin—Oral
_____	016 Corticosteroids—Oral
_____	006 Coumarin-Type Anticoagulants
_____	005 Digitalis Medicines
_____	034 Ergot Derivatives
_____	010 Erythromycin
_____	026 Ethosuximide
_____	001 Furosemide
_____	024 Guanethidine
_____	022 Haloperidol
_____	023 Hydralazine
_____	035 Indomethacin
_____	015 Insulin
_____	038 Iron Supplements
_____	033 Levodopa/Carbidopa and Levodopa
_____	021 Lithium
_____	014 Methyldopa
_____	030 Metronidazole
_____	040 Nifedipine
_____	013 Nitroglycerin Sublingual Tablets
_____	011 Nonsteroidal Anti-Inflammatory Drugs
_____	007 Oral Antidiabetes Medicines
_____	003 Penicillins—Oral
_____	036 Phenylbutazone/ Oxyphenbutazone
_____	019 Phenytoin
_____	037 Quinidine/Procainamide
_____	020 Sulfonamides
_____	008 Tetracyclines
_____	002 Thiazide Diuretics
_____	029 Thyroid Replacement
_____	025 Valproic Acid
_____	039 Verapamil
_____	028 Xanthine Derivatives—Oral
NEW PMIs now available!	
_____	049 Acetaminophen
_____	050 Amiloride and with Thiazide
_____	043 Antihistamines
_____	047 Aspirin
_____	044 Bronchodilator Aerosols
_____	054 Clonidine
_____	048 Codeine
_____	056 Diphenoxylate with Atropine
_____	057 Isotretinoin
_____	059 Methotrexate (for psoriasis)
_____	055 Methysergide
_____	045 Pentazocine—Oral
_____	041 Phenothiazines
_____	058 Potassium Supplements
_____	052 Prazosin
_____	046 Propoxyphene and with Aspirin or Acetaminophen
_____	053 Spironolactone and with Thiazide
_____	060 Steroid and Antibiotic Eye Drops
_____	051 Triamterene and with Thiazide
_____	042 Tricyclic Antidepressants
_____	Total number of pads (5 pad minimum, 50 PMIs per pad)
$ 1.00	Per pad
$ _____	Subtotal
$ _____	Residents of IL and NY must add appropriate sale tax to subtotal
$ _____	Total payment (check enclosed)

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 533
- ☐ DEAN'S MESSAGE, 535
- ☐ ENCORES!, 535
- ☐ CORRESPONDENCE, 539
- ☐ SCAM OF THE MONTH, 541
- ☐ CORRECTION, 541

☐ NOTES & NEWS

FMA Committee on Impaired Physicians to hold workshop

The FMA Committee on Impaired Physicians will conduct the sixth in its series of "Workshops on Intervention with Impaired Physicians" in Orlando in September.

The two-day program will be presented on Saturday and Sunday, September 28-29, at the Orlando Hyatt House, according to Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee. The Hyatt is located at the intersection of Interstate 4 and U.S. 192 west of Orlando and near the entrance to Disney World. The program will begin at 9:00 a.m. and end at 5:00 p.m. each day.

Dr. Selander said the program will cover, among other things, legal responsibilities, recognition of chemical dependency, substances commonly abused, intervention techniques and aftercare. IPP Medical Director Roger A. Goetz, M.D., is course director.

The program was endorsed by T. M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs.

"This program is of special importance to hospital medical staffs," Dr. Daniel said. "Medical staffs often are faced with the problem of an impaired physician in their midst, and all too often they are not sufficiently prepared to deal with it. The Intervention Workshop should be of great value to medical staffs in this regard."

There will be no registration fee, and AMA Category I CME Credit will be offered. Persons desiring overnight accommodations should call the Hyatt House at (305) 396-1234. Be sure to tell the reservation clerk that you are with FMA in order to qualify for the special rate of $70 per night.

In order to register for the Workshop, please send name, address and hospital you are representing to: Mr. Edward D. Hagan, Director of Medical Services, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida, 32203, or call (904) 356-1571.

Frank H. Netter, M.D., honored by Georgetown University

Accompanied by an overwhelming applause, world-renowned medical illustrator Frank H. Netter, M.D., of Palm Beach, Florida received an honorary Doctor of Science degree from Georgetown University School of Medicine at the school's recent commencement exercises in Washington, D.C.

When conferring the degree, Rev. Timothy S. Healy, S.J., President of Georgetown University, quoted Ralph Waldo Emerson, stating, "In the hands of the discoverer, medicine becomes a heroic art." Rev. Healy added that, "In the hands of Frank Netter that 'heroic art' is indeed discovered and the entire medical community has reaped the rewards.

Regarded by many as the world's greatest medical illustrator, Dr. Netter is best known for his widely acclaimed *Ciba Collection of Medical Illustrations*. This nine-book series covers the anatomy, embryology, physiology, pathology and diseases of man, body system by body system.

Dr. Netter, who graduated from the City College of New York, studied art at the National Academy of Design and the Arts Student League and worked as a free-lance commercial artist before entering New York University Medical College, where he earned his M.D. degree in 1931.

He completed an internship and residency in general surgery at Bellevue Hospital in New York before concentrating totally on art. For the past thirty-five years he has been under exclusive contract to the Ciba-Geigy Corporation.

Currently, Dr. Netter is working on additional books in the Ciba Collection; the *Nervous System Part II*, and the *Musculoskeletal System, Part I*. He also continues to illustrate Ciba-Geigy's bimonthly journal, *Clinical Symposia*.

"Eat your spinach" can be terrible advice for sulfite-sensitive kids

Coughing, gagging children thought to be choking on food actually may be in the throes of an allergic reaction to sulfiting agents used to preserve foods.

A 7-year-old boy from Maryland who violently coughed, retched and vomited minutes after eating vegetables from a restaurant salad bar is the world's

youngest documented victim of sulfite sensitivity, according to an article in the May issue of the *Annals of Allergy*.

Allergic reaction to sulfiting agents previously had been reported only in adults and children over 12, said Dr. Stanley I. Wolf, co-author of the *Annals* study. The *Annals* is published by the American College of Allergists.

Previous cases of sulfite sensitivity in young children may have gone unrecognized because the symptoms disappear rapidly and may have been attributed to choking on food, said Dr. Wolf, Clinical Professor of Child Health and Development at George Washington School of Medicine.

Sulfiting agents are used in some restaurant salad bars and in some packaged food to prevent browning, eliminate bacteria and increase storage life. Many restaurants have discontinued use of the controversial additive because it may cause adverse reactions, ranging from hives to anaphylactic shock, in sensitive persons.

Before diagnosis, the 7-year-old boy had suffered symptoms on at least five separate occasions after sampling salad-bar fare. His mother, who at first thought the boy was choking on food, told doctors that, on each occasion, the boy's symptoms disappeared within 20 to 30 minutes after onset.

His allergy was confirmed when, under medical supervision, he was given an oral dose of the same sulfiting agent used in the restaurant and his symptoms resurfaced. The boy also tested positive when given a skin test using the same agent. Skin tests alone are not always conclusive, Dr. Wolf said.

Dr. Wolf advises parents and pnysicians to suspect sulfite sensitivity if a child suffers coughing, vomiting, itching, hives, swelling or asthma-like distress after eating salad-bar or other foods containing sulfiting agents. While facial flushing is a symptom of this allergy in adults, a sensitive child may turn pale, Dr. Wolf said. Asthmatics should be especially alert to these symptoms because studies show 5% to 10% of all asthmatics are hypersensitive to sulfiting agents.

A child with these symptoms should be taken to an emergency room or a physician for immediate treatment.

Major food categories to which sulfiting agents are often added include, but are not limited, to: Avocado dip and guacomole, beer, cider, cod (dried), fruit (cut-up fresh, dried or maraschino-type), fruit juices, purees and fillings, gelatin, potatoes (cut-up fresh, dried, frozen or canned), salad dressing (dry mix), relishes, sauces and gravies (canned or dried), sauerkraut and cole slaw, shellfish (fresh, frozen, canned or dried), clams, crab, lobster, scallops;, shrimp, soups (canned or dried), vegetables (cut-up fresh, frozen, canned or dried), fresh mushrooms, wine vinegar, wine, and wine coolers.

The Food Allergy Committee of the American College of Allergists suggests the following preventive measures:

- When ordering food in a restaurant, ask if sulfiting agents are present in the specific item you desire. Most restaurants have discontinued their use upon recommendation of the National Restaurant Association. However, they are often present in items purchased from suppliers. Press the manager for a definite answer, but he may not be aware of sulfites added by suppliers.
- If the manager seems in doubt or you do not receive a definite answer, order an item which is not sulfited such as chicken, eggs, meat or cheese.
- Read labels on all processed foods. Sulfiting agents may be mentioned on the label and their presence will be indicated by one or more of the following terms: sulfur dioxide; potassium bisulfite or potassium metabisulfite; sodium bisulfite, sodium metabisulfite or sodium sulfite.

FMA establishes medical/legal hotline

The Florida Medical Association Board of Governors and the House of Delegates have approved the establishment of a medical/legal "hotline" to serve the FMA membership and component county medical societies. The purpose of the"hotline" is to provide a designated direct line to FMA's legal department to assist members in obtaining answers to their medical/legal questions. Questions dealing with the Medical Practice Act, or with issues confronting physicians as they practice will be addressed, if possible, over the phone. Frequently, however, there will be instances where the caller will be asked to put his question in writing and a written response to the caller will be sent as soon as possible. This is to ensure that the answer being provided is complete and responsive, particularly when the issue is multifaceted.

The "hotline" will operate from the FMA Headquarters Office during normal business hours (8:30 a.m. - 4:45 p.m.), weekends and holidays excluded, and available to receive calls from any member or component county medical society. The "hotline" number is (904) 356-0056.

The legal department cannot answer questions dealing with a physician's personal and private business or family matters. The legal department is also not permitted to participate in any court hearings in support of a member unless such action is approved in advance by the FMA Board of Governors.

The FMA is pleased to provide this valuable service and hopes that it will be of assistance to its membership and component county medical societies.

JCAH seeks qualified physicians as surveyors

Interested in an opportunity to enhance your knowledge of the nation's health care system while helping to improve patient care? If so, you should consider becoming a physician surveyor for the Joint Commission on Accreditation of Hospitals (JCAH).

The JCAH is currently recruiting both full-time and part-time physician surveyors for its Hospital Accreditation Program. As a surveyor, you'll be part of a survey team that visits facilities throughout the country to determine their progress in meeting JCAH's standards in patient care. During the accreditation survey, you'll discuss your survey findings with key medical staff members and hospital personnel and provide consultation and education. Your findings will help JCAH's Board of Commissioners to make a final accreditation decision.

To become a physician surveyor, you need:

- a current medical license;
- at least 15 years of service on a hospital medical staff with committee and leadership responsibilities;
- extensive clinical and patient care management experience;
- strong oral and written communication skills; and
- excellent physical health.

The benefits of becoming a physician surveyor include a yearly salary and per diem expenses, noncontributory life insurance, medical insurance, a retirement plan, and an optional, tax-sheltered annuity plan. In addition, you'll enjoy a liberal vacation and holiday policy.

The position also offers many educational opportunities and challenges. As Donald Weiss, M.D., a physician surveyor, comments, "As a surveyor, I am continuously meeting with physicians who are eager to show me the latest techniques in surgery, nuclear medicine, drug therapy, and a number of other medical areas.

"Most importantly, however, I feel that as a surveyor, I am helping medical staff members and other hospital personnel become aware of the value of voluntary assessment and how they can help improve the quality of care provided within their facilities."

If you are interested in this important challenge and career opportunity, please send a copy of your curriculum vitae to: Kristin V. MacRae, Director of Personnel, JCAH, 875 North Michigan Avenue, Chicago, Illinois 60611, (312) 642-6061.

DEAN'S MESSAGE

Brother against brother?

In June every year, thousands of young men and women graduate from medical school. In 1985, slightly over 16,000 people received their M.D. degree in the United States and entered graduate medical education.

Never before have young physicians entered the mainstream of medicine with so many threats to their profession as exist today. Each physician can identify these threats — malpractice crisis, hospital-physician relations, cost containment, new technology, consumer group organizations, health maintenance plans, open marketing by physicians, and in some communities physicians are even attempting to restrict the practice of other physicians using legal mechanisms. In our own state, it appears that the corporate practice of medicine is now legal. What's next?

Are we rapidly returning to the spirit of the Civil War when it was "brother against brother, father against son?" Will physicians be divided into two camps — fee-for-service *versus* corporate medicine? Will a schism develop between physicians that exists between hospitals? Will the battle lines drawn by competing hospitals pit medical staff against medical staff — "brother against brother, father against son?" The profession may be able to preserve and protect that which is good.

How? There are no easy answers. However, it is crystal clear that very active involvement in the local medical society, Florida Medical Association, American Medical Association, and your specialty organization are keys to the future. Encourage and invite young physicians to be active in medical organizations — listen to them, involve them. If we do not work together, our divided house will surely fall.

William B. Deal, M.D.
Dean and Associate Vice President
University of Florida College of Medicine

ENCORES!

Passive smoking: has the threat proved true?

Cigarette smoking is our greatest public health problem. From lung cancer to premature menopause, emphysema to ulcers to crow's feet, the list of its nasty sequelae seems to grow every year.

Nonsmokers look on the habit with pity or contempt, plus an occasional flash of annoyance when smoke drifts too close. Except for some asthmatics, though, few see it as a personal danger. Researchers are not so confident. Hints that someone else's smoke can be more than an irritant have sprinkled the literature since the late 1960s.

As recently as 1979, however, the Surgeon General's report reassured us that healthy nonsmokers show "little or no physiologic response" to passive smoking. Five years ago, three studies promoted the issue from a minor to a major controversy, where it remains today. It's still not clear if passive smoking leads to long-term clinical disease, but each study raised ominous questions.

Flow rates flag in passive smokers • From 1969 to 1979, researchers at the University of California at San Diego evaluated pulmonary function in 2,100 smokers and nonsmokers. Measuring forced mid-expiratory and end-expiratory flow rates, they charted the usual deterioration from abstainers through light, moderate, and heavy smokers. But since nonsmokers were divided into those who worked more than 20 years around smokers and those who did not, the results also showed the effect of chronic passive smoking. It was not good. Not only did passive smokers score lower than controls, their flow rates were similar to those of light smokers.

Expiratory flow rate is the most sensitive measure of small airway function. A drop is the earliest abnormality shown by a smoker's lung. Passive smokers in this study had a small but significant impairment — too little for clinical disease, but enough to support the conclusion that chronic exposure to tobacco smoke at work harms the nonsmoker.

Parental smoking called into question • Also in 1980, Harvard researchers reported on the relation between respiratory illness, parental smoking, and pulmonary function in children. In their study, children whose parents smoked had a lower forced expiratory flow (FEF) and a higher incidence of persistent wheezing. In fact, parental smoking was the strongest predictor of a low FEF — stronger than a child's history of persistent wheezing, lower respiratory disease, or asthma.

This was not the first such report. Over the previous decade half a dozen surveys from Britain and the U.S. found more respiratory illness in children of smokers. Since then, it's become clear that bronchitis, pneumonia, and other lower respiratory diseases are significantly more common in children less than one year old with one or two smoking parents — and probably more common during the second year.

Studies at older ages are not unanimous, but most show that children of smoking parents have more acute respiratory illness, chronic cough, phlegm, and/or persistent wheeze. One ingenious French study used tonsillectomy as a measure of recurrent respiratory illness. When 4,000 children between the ages of 10 and 20 were asked (1) if they had had a tonsillectomy and/or adenoidectomy, and (2) if their parents smoked, their answers revealed a surgery rate of 28%, 41%, and 51% for zero, one, and two smoking parents, respectively.

Viewing the evidence, the latest Surgeon General's annual report agrees that passive smoking has a measurable ill effect on the development of lung function in children. The data are impressive enough to suggest that pediatricians include parental smoking habits in a child's medical history. More than one expert urges doctors to tell parents of children with recurrent respiratory illness to quit.

Does passive smoking contribute to cancer? • Idle speculation until 1981, the link between passive smoking and cancer erupted into a heated debate that persists with no clear winner. The trigger was a study showing that women whose husbands smoked more than a pack a day died of lung cancer twice as often as controls.

Appearing in the *British Medical Journal*, this conclusion was drawn from a massive survey of 265,000 Japanese done between 1966 and 1979. It explored the health consequences of social factors, such as occupation, marital status, and drinking and smoking habits, so there was no special attention paid to passive smoking.

The Tobacco Institute challenged this finding, backing its skepticism with an analysis by an outside expert who cast doubt on the statistical methods. Other experts came to the survey's defense, and both the study and the quarrel became an international news event.

Also in 1981, a small Greek study concluded that wives of smokers tripled their risk of lung cancer. Hong Kong researchers found no increased risk, nor did an American Cancer Society report that evaluated two large surveys from the 1950s and 1960s. A 1984 cooperative study of lung cancer in nonsmokers found an increased risk in men exposed to smoke at work. Unfortunately, researchers failed to ask about passive smoking until the eighth year of their ten-year project. The other studies are also incomplete. None was originally designed to investigate passive smoking.

The two-cigarette threshold • In 1983, a National Institutes of Health conference concluded that the effect of passive smoking on respiratory function "varies from negligible to quite small." Researchers are frustrated by the small doses they must deal with. A nonsmoker heavily exposed to tobacco smoke probably inhales the equivalent of two cigarettes a day.

Two seems to be a threshold level. According to a National Cancer Institute analysis of many studies, a person can smoke two cigarettes a day without measurably increasing his mortality risk above that of a nonsmoker. The key word is "measurably." There may be toxic effects at lower doses, but today's methods cannot recognize them. Tomorrow's may be more sensitive.

Hazardous or not, smoky air is unpleasant. While it's no longer considered eccentric to complain, there are more psychological barriers than we realize. Only one third of Americans smoke, yet a survey of nonsmokers found that most believe they are in the minority.

But the atmosphere is changing. Five years ago, statewide anti-smoking referendums were always soundly defeated. Nowadays, despite massive spending by tobacco companies, the margins of defeat have narrowed dramatically.

Legislators have responded to this change. Minnesota, Utah, Connecticut, and Arizona, plus over 30 cities and counties, have laws restricting smoking in public areas. In San Francisco, an employer must satisfy a nonsmoker's complaint, even if it means banning smoking entirely. A similar law recently passed in Los Angeles. A few companies have deciced to prohibit smoking entirely, and some — notably hospitals — prohibit smoking both on and off the job. Prospective employees interviewed for job openings simply will not be hired if they admit to smoking. A number of companies have offered financial rewards and other incentives to smokers who quit.

If progress continues, cigarette smoking could become a problem restricted to smokers themselves. Nonsmokers may sympathize, but they are increasingly unwilling to share the smoke.

Mike Oppenheim, M.D.
Los Angeles, California

Reprinted with permission from *Respiratory Medicine Today*, Vol. 1, No. 3.

Too many of us?

We physicians have been told, by a seemingly knowledgeable study panel, that our profession is facing an overabundance of practitioners by the year 1990. We have been told this again and again. In fact, I am becoming rather tired of hearing of our upcoming physician surplus. Perhaps those who preach this doctrine feel that they must keep calling it to our attention so we do not forget it. However, since hearing of this dreadful threat, I have been giving some thought to the problem. Some of the proposed solutions include closing some "marginal" medical schools and assigning quotas to each medical school. Other solutions have been offered — some of which are quite complex.

After some consideration of the problem, I think I have solved it. Before I describe this brilliant plan, however, let us think back to our reasons for selecting a career in medicine in the first place. To our untrained minds, medicine seemed very glamorous. To be summoned to the patient's hospital room, rushing in at the very last moment and administering the lifesaving injection, and to hear our names paged all over the hospital — these are heady experiences. It may be that you entered medicine for more altruistic reasons, perhaps to better the human race. No matter — when we got into medicine, we all found the same thing. What a disappointment it was to learn how really mundane the day-to-day practice of medicine is.

People would never suspect, watching one of the popular soap operas on television, that a large portion of usual medical care has to do with flatus, phlegm, and Foley catheters. Rather than addressing the commonplace problems of emesis-basin medicine at the bladder, bowel, skin, bedpan, and catheter level, the media ply the American public with scientific advances and breakthroughs or, on the other side of the coin, provide stories of medical malfeasance generating enormous sums of money by way of litigation. Although most television shows carefully screen us from life's more basic functions, the advertisers who sponsor the shows certainly do not spare us. There are more than enough commercial advertisements for expectorants, laxatives, sanitary napkins, and hemorrhoidal preparations to serve as a constant reminder of what people are really concerned with.

Dr. Richard Lee of Children's Hospital, Buffalo, speaks of this as the "bedpan gap." Throughout medical training, our esteemed professors, either through inexperience or embarrassment, speak of the monumental and tend to ignore the mundane aspects of medical and surgical practice. They dwell on the desultory, the diverse, and the dramatic aspects of our craft, leaving the less glamorous part of medicine to be imparted to us by others. I am not implying that this is necessarily wrong, but where then does a medical student learn about the everyday runny nose and sore back and the type of medicine to use for hemorrhoids?

Nearly all of us who are "a little older" came to appreciate the real world of medicine on the wards of a hospital. The night nursing supervisor taught me the tricks of passing a gastric tube, restarting an IV, and inserting a urinary catheter and what sterile technique meant. Although I still revere and respect nearly all of my medical school professors, I often

think that the nurses at the hospital taught us almost as much, but at much less cost and on a different level.

Since our clinical partners, the nurses, have succumbed to the fantasy world (the same one physicians are in) of extra degrees, superspecialization, and "extended care plans," I wonder where the new medical school graduates will get their intoduction to the sights, smells, and stressful needs of sick people? I now have fond memories of the fussy spinsterhood of Miss Jones, the head nurse on the urology ward of the hospital where I interned. When we lowly interns came on her ward, we washed our hands and addressed all patients, many of whom were outcasts and indigents, as "mister" so and so. She would tolerate no less, and on that ward she was the boss. Even the urology attendings avoided offending Miss Jones. If there was ever a patient advocate, before that term became popular, she was one! To a chronically tired intern who always seemed to be two patient workups behind, Miss Jones's fussiness was not appreciated, but to the patients on her ward, she was the epitome of gentle, competent care.

Getting back to my solution to the physician surplus, I contend that if aspiring premedical students were aware of how common and ordinary most of what physicians do is, the number of medical school applications would drop precipitously. As it is now, much of the public perceives medicine as constantly poised on the brink of fabulous scientific breakthroughs. These perceptions are produced primarily by the media, which continually titillate the public into expecting more from medicine than is currently feasible. As an example, I recently read an article in the lay press about what a miraculous and lifesaving procedure a bone marrow transplant is, without more than a mere mention in passing of its drawbacks, expense, and frequent failures.

I suggest that we make up a folder to be mailed to each premedical student in his or her sophomore year of college. Sending it at that time would allow students to change their major without too much difficulty. We might call it the "Practitioner's Premedical Predictive Package," or the "Four-P" test for short. The folder might contain several "scratch and smell" patches representing, for example, the odor of a fungating breast lesion, the smell of apurulent abscess, and concentrated body odor. It should also include several color plates showing severe trauma cases, maybe an anencephalic infant, and a radical mastectomy. Next we could include a tape recording of some of the sounds common to medicine, such as the sound of a bone saw removing a window in the skull, the sounds of children being immunized, and the disconnected rambling speech of a schizophrenic. Finally, the last page of the folder should list a few of the situations physicians frequently must face. For example, what do you say to the pregnant woman who, by ultrasound, has just been discovered to have a fetus that is grossly abnormal? Whose instructions do you follow when the patient requests to be told the truth and the family members all stoutly insist that you should not disclose the nature or severity of the disease to the patient? What do you say to the husband of a young woman with two small children who has just been determined by biopsy to have inflammatory carcinoma of the breast?

I believe it would be easier to deal with the physician surplus by reducing the number of students entering medical school than by reducing the number of approved residencies, as our current method dictates. One danger in the current method is that it may force medical school graduates into general or family medicine by default. The field of primary care is rather demanding, and physicians who are not ready to make the commitment to this type of practice may well do more harm than good if they are forced to enter this field!

If students decide to continue into medicine, despite forewarnings, how will they succeed in overcoming bedpan gap? It is very difficult to do the extraordinary if we cannot do the ordinary. Somewhere along the line, young physicians need to learn that they will see 1,000 runny noses before a patient with nasopharyngeal cancer comes along and that hemorrhoids are apt to be a much larger part of their practice than AIDS.

When you hear hooves approaching, look for horses not zebras. Day-to-day medical problems constitute the "stuff" of medical practice, and much of that is unglamorous. If it were possible for us veteran physicians to make available to premedical students some of the sights, sounds, and smells of everyday medicine and impress on them the ordinariness of many of our day-to-day activities, we might just be able to solve our "overpopulation" problem by ourselves and keep the federal government out of it.

J. Mostyn Davis, M.D.

Reprinted with permission from *Postgraduate Medicine*, Vol. 77, No.6.

Will the real family physician please stand up

With the impending overabundance of physicians and the rapid proliferation of alternative health care delivery systems, everyone wants to be a family physician. Free-standing emergency centers advertise as your neighborhood family doctor. Health maintenance organizations proclaim that enrollees will have their own family doctor. Surgical subspecialists

who cannot obtain hospital privileges in their field open an office to practice family medicine. While thinking about this problem, the old TV show "To Tell The Truth" came to mind. Three contestants tried to fool the panel who were trying to guess the identity of the real guest. After they made their choices, Gary Moore, the host, would say, "Would the real Mr. Smith please stand up." As many times as not the panel was wrong. So it is today with family practice; no one is sure which one of us is the real family physician.

There is no law governing what label a physician places on himself. Many internists call themselves cardiologists even though they are not board certified in that subspecialty. There is no law that says an orthopedic surgeon must be board certified to practice orthopedics. Many general practioners call themselves family physicians even though they are not board certified in our specialty. Until 1978 a GP could take the boards in family practice by practicing from three to six years after medical school. After 1978, however, this pathway closed and now only those who complete a full three-year family practice residency are eligible to take the board exam. Obviously the title family physician is being applied to many more individuals than are board certified.

The specialty of family medicine is so well established now that it need not be the dumping ground for any physician who has a medical license. It's time we throw out the idea that anyone can practice family medicine. Departments of family practice in hospitals should be for family physicians and not for any misfit who wants hospital privileges.

If HMO's and free-standing centers are found to be employing retired neurosurgeons and pathologists as their "family doctors," it is incumbent upon us to bring this to the attention of the public. I don't deny that plenty of good GP's may originally have been trained in different specialties and practice high quality family medicine. Likewise, some board certified family physicians may be borderline practitioners. A doctor who has made the effort to take the boards and been recertified demonstrates a desire to remain at the forefront of his specialty. Simply using the title "family physician" does not guarantee quality medical care. It is imperative that we teach the public to ask, "Will the real family physician please stand up."

Lee A. Fischer, M.D.
West Palm Beach

Reprinted with permission from *Florida Family Physician*, Vol. XXXIV, No. 4, Fall 1984.

CORRESPONDENCE

Lee County Medical Society offers suggestions

Dear Editor: I am writing as the Administrative Secretary of the Lee County Medical Society Bulletin on a number of points of information I would like to share with you.

In the past few years I have noticed no new bulletins, newsletters or magazines have been established by county medical societies which have never set one up. I am sure that their memberships have become larger and need this type of communications. I really feel that sharing information among the county societies is beneficial to all and is a means for the local talents who write to become involved. I would like to encourage the FMA to promote involvement by all county medical societies.

The FMA awards competition would also increase and add more meaning to participation by county medical societies.

Regarding the awards presentation, I am very proud of our Bulletin and feel a lot is contributed to its success by some of my contributions. I do not want to take anything away from our talented editors as they work very hard to make the publications a viable means of communications. I would like to make a suggestion that the county medical society executives involved with their local publications be a part of the awards ceremony and thus give us increased incentive to publish a better tool of communications and share in its success.

In recent years a workshop was set up by *The Journal* to help county medical societies establish a publication of high quality. For anyone just beginning a publication, there does not seem to be anyone to contact and it is a trial-and-error venture with some disappointments that insure failure and no desire to try again. This is also true of established publications as we are placed into the world of the print media, dealing with printers, layout personnel, material, style, finance, etc.

Recently, at one of our meetings, it was pointed out by the FMA leadership that some negative material in one of our local county medical society newsletters would have been better left unprinted. Personally, this material was of interest to our office and membership and was not taken in a negative way. It does point out that we see things on different levels and that county medical societies are without a resource for many items that come across our desks each day dealing with the print media communications. As county executives we usually look to the state organization for direction and when none is there, we must make decisions on the local level.

Above are some of the thoughts I have had regarding the local county medical society publications. I am not sure they fall in the realm of the Editor of *The Journal* but I thought I would start here first. Thank you for taking time to consider the above thoughts.

Ann Wilke
Administrative Secretary
Lee County Medical Society Bulletin

Editor's response

Dear Ms. Wilke: Thank you for your thoughtful letter. I will address your concerns in my capacity as *The Journal* editor, and as a former editor of a county medical society bulletin.

County medical societies without bulletins, newsletters, or magazines certainly need to be goaded into setting these up as one way of enhancing communication among members, increasing awareness of issues, and stimulating participation in the activities of organized medicine. Although there is a core of excellent publications put out by certain county medical societies, as evidenced by the annual FMA Awards Competition, the number of societies in the state without newsletters or bulletins is still impressive. Part of the problem may be the small size of some county medical societies, with very little to report about; part may be financial, since a project like this would entail additional costs to society members. But what about those medical societies where neither one of these factors comes to play?

In my experience as a former bulletin editor for a medium-sized county medical society, Volusia, the most important ingredient in setting up a successful publication, regardless of any perceived obstacle, is in organizing a group of dedicated physicians willing to commit the time and energy into the project, and on a consistent basis. It is like a labor of love. Previous journalistic experience in college helps, but is not necessary. After all, very few of us immersed in physics, biology, and chemistry could find the time to be amateur journalists as well. What is more important is for the physicians to hatch the ideas, and to express them well in correct English. The mechanics of setting up the paper and of proofreading, copy editing, and making the publication presentable can be learned in a few hours at the printing press.

For those who need more help and professional advice, the FMA editorial staff will try to provide assistance in any way it can. Most members of our editorial staff were once editors of their county bulletins, a few still are, and all went through the same rigors of putting out a publication. If there is enough demand, *The Journal* will explore the idea of setting up a workshop on how to develop a medical publication, perhaps in conjunction with the annual FMA meeting. Sandoz also sponsors a similar workshop periodically, with this year's meeting scheduled to be held in Chicago in late October. For others who want to learn things in a hurry, a few books on how to produce a small newspaper or magazine should be helpful.

The Journal of the Florida Medical Association would like nothing better than to see a flowering of editorial talents in the component societies of the FMA. That should make our annual awards competition even better and more interesting. The idea of expanding the annual Editor's dinner to include other people, particularly those who have contributed to their publications, is quite appropriate. As the new editor of the JFMA, I will see to it that this is done. I might add that several other physicians had expressed the same idea at this year's FMA annual meeting.

Finally, your letter touches on the delicate point of what is proper to print in your publication. The nation's most prestigious newspaper, *The New York Times*, carries the blurb of printing "all the news that's fit to print." But who is to judge what is fit to print, and what is unfit? While it is certainly true that it may be better to leave unprinted certain "negative materials," there are occasions where publication of such materials may serve a purpose. Most newspapers and magazines, even the best ones, thrive on printing a lot of what is negative. I am not saying we should do that. In a situation where questions of propriety, ethics, confidence, legality, or delicacy crop up, the editor and his staff should always exercise their best judgment, and such judgment may come about only after painful and agonizing appraisal of the facts at hand, perhaps in consultation with those who have expertise on the subject in question. It is true there is no central clearing-house where an editor confronted by the kind of situation above can turn to; nevertheless, it is still prudent to consult with the county medical society or the FMA or any appropriate body if the publication of certain materials may be inimical to the interests of these organizations. Without belaboring the point, a common-sense approach to potential problems still works best, with no cry for censorship at that.

Your letter, I hope, will stir some dormant souls and stimulate them into the kind of involvement in their county medical societies that other physicians are already engaged in. Communication will always be a vital link in the success of organized medicine. As an editor, I applaud your concern and efforts.

R. G. Lacsamana, M.D.
Editor

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"Sickle Cell Anemia Scam"

Investigations in the St. Louis area have uncovered an innovative scam involving the Schedule III Codeine containing analgesics, especially TYLENOL #3 and #4.

Children who have been diagnosed as having Sickle Cell Anemia were being used by their parents to obtain huge quantities of TYLENOL #3 and #4. Medicaid was paying for these prescriptions and reported this situation to Bureau of Narcotics and Dangerous Drugs.

Further investigation revealed the nature of the scam involving a family with three children, one boy who was confirmed to have Sickle Cell Anemia and two girls who apparently had nothing wrong with them at all. Several physicians were prescribing controlled drugs for the boy but one physician in particular was also prescribing numerous TYLENOL #3 and #4 prescriptions to the two girls.

The boy's primary physician was contacted and reported the pain associated with Sickle Cell Anemia ran in cycles and the boy should be able to go for several days without the use of any controlled drugs until they were needed again.

Discussion with the physician prescribing for the two girls indicated the boy's father made the physician believe both of the girls also had the disease and that was the reason he was prescribing so many controlled drugs for them.

It was later learned that the father was apparently involved in selling the TYLENOL #3 and #4 and that his wife was an addict. Since this situation was uncovered, even though the entire family is "locked in" to one doctor and one pharmacy under the Medicaid program, none of the family members have been seen or heard from. This is another unfortunate case of parents unscrupulously using their children to divert controlled drugs.

Reminder • Physicians should remember that generally patients obtaining large quantities of controlled drugs need more monitoring than the patient who is not receiving large quantities. The physician should be certain in his or her own mind that the patient is using the controlled drugs in the proper and reasonable manner intended and investigate unusual requests for additional quantities or increased drug strength.

CORRECTION

Improving care for indigents

The following sentence in Correspondence of the June 1985 issue, page 456, first paragraph, should have read "However, as medical care has become expensive and providing care for the indigent is such a problem, the time has come for this noble idea."

YOUTH AT RISK



Outward Bound® Directive
A Special Program That Works.

The Hurricane Island Outward Bound Directive Program is a deliberately structured outdoor educational process dealing with motivational and behavioral problems.

By overcoming the challenges of this special Outward Bound course, the students steadily develop their self-image, sense of responsibility and the will to achieve.

Many schools have recognized the significance of the Outward Bound experience by granting high school credit during the school year.

Florida Program — February-December Maine Program — June-September.

Send for free descriptive catalog or call toll-free 1-800-341-1745 for more information.

Inquire now, before it's too late!

Name _____

Street _____

City _____ State _____ Zip _____

☐ Send financial-aid information.

Send to: Hurricane Island Outward Bound School, 823 Thomasville Rd., Tallahassee, FL 32303.

C

He Thought That Drinking Wouldn't Make Any Difference, Even Though He Was on a New Medication. But It Did.



Now he knows that alcohol and some medicines don't mix. In fact, more than half the 100 most prescribed drugs have at least one ingredient that can cause trouble if taken while drinking alcohol. The result of mixing these drugs (alcohol is a drug) may be no more than simple temporary illness, but some combinations can be dangerous, even deadly.

So, don't make a test tube out of your body. Be sure to tell your doctor or druggist about any medications you are taking and be sure to ask about the consequences of mixing a newly prescribed drug with alcohol.

Also, make it a habit to check the label carefully when you get a drug, whether it's a prescription or over-the-counter medication.

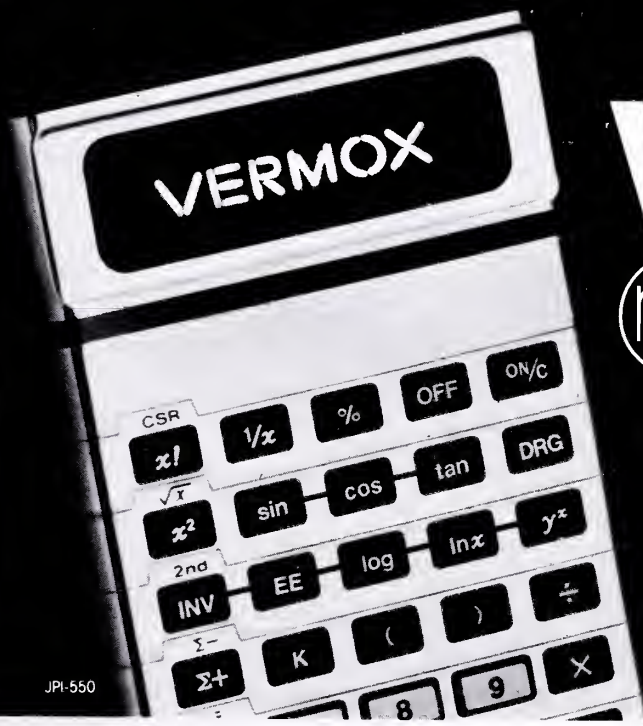
And when you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.

No need for dosage calculations...



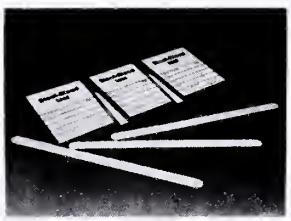
VERMOX®
(mebendazole)
CHEWABLE TABLETS

JANSSEN PHARMACEUTICA
Piscataway, NJ 08854-3998

JPI-550

© Janssen Pharmaceutica Inc 1985

50,000 people will be saved from colorectal cancer this year. You can save one.



Save yourself! Colorectal cancer is the second leading cause of cancer deaths after lung cancer. More than 90% of colorectal cancers occur equally in men and women past age 50. Early detection provides the best hope of cure. That's why if you're over 50, you should take this simple, easy slide test of your stool every year.

Two days before the Stool Blood Test, you begin an easy-to-follow diet listed in the kit. The kit is chemically treated to detect hidden blood in the stool which usually indicates some problem in the stomach or bowel, not necessarily cancer. Positive tests must be followed by further testing to find out what the problem is.

Other tests for colorectal cancer you should talk to your doctor about: digital rectal exam (after 40), and the procto test (after 50). Tell him of any family history of colitis, polyps, and any change in your bowel habits which could be a cancer warning signal.

The American Cancer Society wants you to know.



AMERICAN CANCER SOCIETY®

Book Review Editor — F. Norman Vickers, M.D.

The social transformation of American medicine

By Paul Starr, Ph.D., 514 pages. Price $24.95. Basic Books.

In this prize-winning book Professor Starr traces the origins of American medicine from colonial times to the present. Full of facts and figures, the book is written in a sociological context. The author teaches at Harvard University and is recognized as an authority on sociology. With his background, Mr. Starr weaves a tale that combines history, sociology and politics into a work that guides the reader through 200 years of American medicine. It is tedious to read in some areas, as the sociological and academic aspects tend to obscure the fascinating story. Most doctors do not know the history of their profession, the struggles it faced and eventually the triumph from a profession without power or respect to one of prestige and authority. For modern day doctors, it is revealing to see that the medical profession was considered one of the lowest professions of early America, a carry-over from the European view. This book is a study of how the medical profession came to power through creating its own authority. This authority was created chiefly to control licensure and educational requirements and to gain control of the hospital environment.

Prior to Medicare in 1965, the medical profession had already fought many battles with trade unions and the federal government over various approaches to socialized medicine. The Socialist Party in 1904 was the first political party to advocate health insurance. This was during the Progressive Era, a period in American history when many popular reforms were enacted into law such as the initiative, direct election of United States Senators, and the recall and referendum. Out of the agitation for social change came the American Association for Labor Legislation (AALL), which was formed by a group of persons who called themselves Social Progressives. The AALL pushed for health insurance, which would include physician's services along with nursing, death benefits and sick pay. Surprising to the leadership of the AALL, many prominent medical leaders, including the editor of the *Journal of the American Medical Association*, worked with the AALL to come up with a plan. However, opposition from the rank and file of American physicians was formidable and its efforts came to an end because of this and the entry of America into World War I in 1917. Germany had a form of social health insurance and anything associated with Germany in 1917 quickly lost favor.

The sentiment for compulsive health insurance reappeared in the 1930's amid The New Deal, an era of government intervention in response to the depression that was sweeping the United States. President Franklin Delano Roosevelt pushed for health insurance in conjunction with the original Social Security Act. The time appeared right. Many doctors were selling peaches on street corners, knocking on doors to drum up business and affected as adversely by the depression as the rest of the population. The California Medical Association endorsed compulsory health insurance and the Michigan Medical Association supported it for a period of time and had a running battle with the American Medical Association. During the 1930's the AMA and the reformers continued to do battle. By the end of the 1940's most of the doctors were against the idea of compulsory health insurance and apparently so were the people. In 1945 a poll was taken to find out public sentiment and the polls indicated that while a ma-

jority would approve national health insurance, only about one third of the population preferred it to a private system. Because of the opposition of national and state medical leaders, Roosevelt decided not to risk confronting organized medicine. There were more attempts during the 1940's and 50's, which the author deals with in detail. Starr traces the advent of Medicare in 1965 to several factors, such as the expanding technology, rising cost of medical care with this technology, use of antibiotics, x-ray, etc. and increasing usage of medical services in a more liberal society. Medicare proved to be a boon to doctors who were paid for seeing patients they had previously treated gratis.

The last several chapters of this book are the most interesting, and also depressing, to members of the medical profession. It was in the 1970's that a crisis was born when the cost of medical care approached 10 percent of the gross national product and the people became disenchanted with the current system. The medical profession resisted any more inroads into its authority and autonomy. The foe was usually perceived to be the federal government. Professor Starr points out the biggest foe was not, and is not, the federal government. It is the rise of corporations and corporate medicine. In a way, medicine has been hoisted on it own petard. For decades we have decried the intervention of government control and asked for private enterprise or the market place to determine the price of medicine. Now the corporations are employing capitalistic principles, enterprise and marketing to the medical needs of this country. Mr. Starr foresees the last decades of the twentieth century as a time of disintegrating autonomy, reduced income for physicians and a change from private practice to the "corporate doctor." The supply of physicians is helping the corporations to move rapidly into a position of control. From 377,000 physicians in the United States in 1975, the number is expected to rise to 600,000 by 1990. For every 100,000 people, there were 140 doctors in 1960, and in 1990 these 100,000 people will have 240 physicians. This will make America one of the most heavily physician-populated countries in the world. Because of this surplus, many newly graduated doctors will find corporate medicine appealing. Doctors in private practice have helped pile dirt on the grave with unnecessary hospital admissions, testing, etc. The corporations have demonstrated they can be efficient and cut costs. Whether or not this will compromise patient care has yet to be proved.

The great illusion of doctors and hospitals throughout the last two decades was that our problems were caused by a liberal government. Starr feels that they were caused by the demands of physicians put upon private insurance and public programs. This has led to measures such as DRGs and the rise of corporate medicine. He does not lay blame in a derogatory manner, but instead feels that it is a combination of inefficiency, patients' demands, and the protection of medical autonomy to the point that no adjustments in the practice were thought necessary or desirable, even in the face of contradictory evidence.

Corporations are moving rapidly to gain as large a share of the medical market as possible. By 1981 nearly 75 percent of all beds in for-profit hospitals were controlled by the three companies of Humana, Hospital Corporation of America and The American Medical International. As the corporations become more powerful, they will try to modify or control the behavior of physicians. This will represent a change from "professional socialization," the process whereby medical students learn the values and attitudes of graduated and established physicians to that of "corporate socialization" as the young doctors learn to do things and act as the company expects.

Starr ends with the sobering thought that this turn of events is a combination of professional and institutional self-interest, failure of the medical profession to provide effective plans for change and to recognize the forces that were in effect the last 20 years. It is a very enlightening and depressing book for in it we see the missed opportunities, wrong decisions, and recalcitrance that have made the medical profession vulnerable to this end. However, there is a bright note. Professor Starr points out that a trend is not necessarily fact and this image of the future of medicine can depend on choices that Americans, which include the medical profession, still have to make.

H. Frank Farmer, Ph.D., M.D.
New Smyrna Beach

• Dr. Farmer is in private prctice of internal medicine in New Smyrna Beach and is newly appointed Historical Editor of *The Journal.*

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where Southeastern Medical Data Systems comes in.

Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

Write or call us for additional information and we'll get back to you immediately.

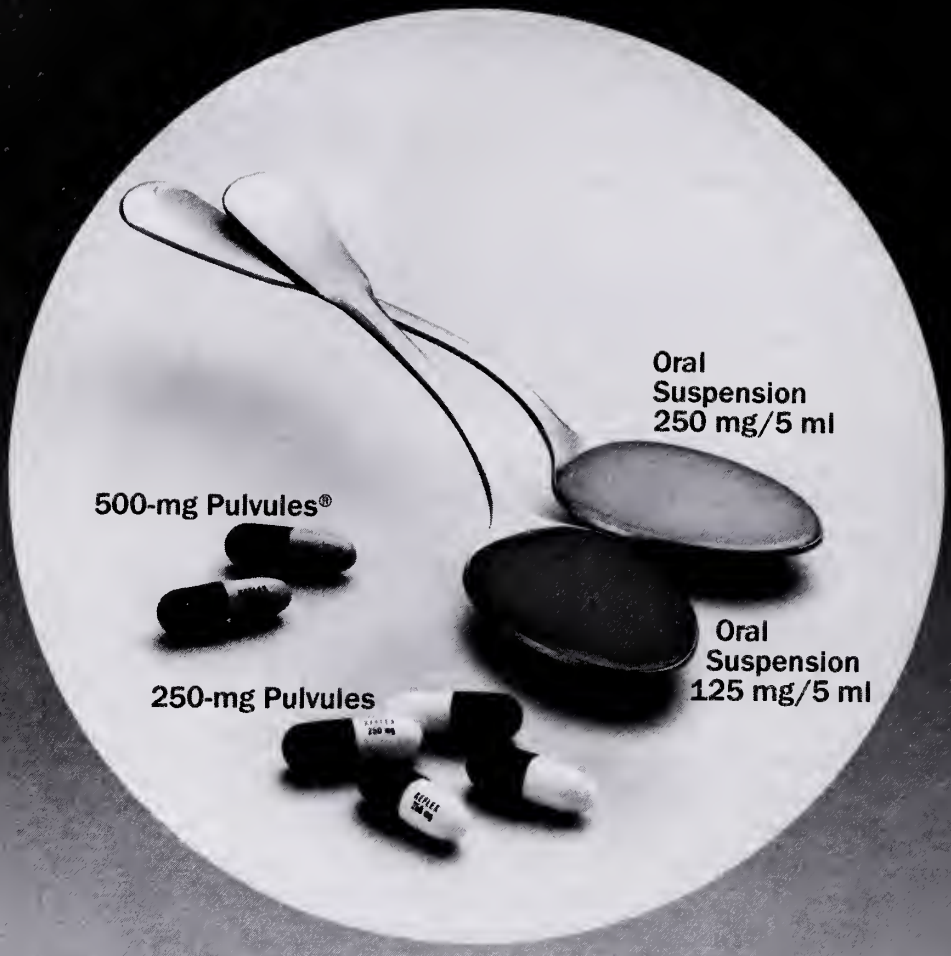
After all, we wouldn't want to try your patience.



southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Medical malpractice — a study in evolutionary politics

At 11:00 p.m., Thursday, May 30th, after more hours, energy and efforts than the FMA staff and leadership could tally, the Malpractice Reform Act of 1985 made its final journey through the Florida Senate. For medicine in Florida, it was the best session in almost ten years. The tide and sentiment of the Florida legislature had shifted. What had been met with skepticism, indifference and even derision in the past had now attained an almost *cause celebre'* status. This legislature had chosen to address an issue the past two previous sessions had refused. What had precipitated this change? What had made the 1985 legislature so different from many of its predecessors?

From the perspective of one who has actively followed this issue through the demise of mediation panels, the "recovery of costs", the yearly attempts by medicine to obtain legislative relief, the court's negative decision on Amendment 9, and finally as a relieved and weary observer of the closing hours of the 1985 session, I have concluded how this whole process had to evolve.

Most would remember from their high school civics course the classic definition of a revolution — that sudden, radical or complete change. While the malpractice crisis has warranted, in the minds of many, sudden, radical or complete change, revolution has never been a realistic much less operative possibility. No matter how frustrating, how miserable or unfair, it is unlikely that physicians in Florida would rise in protest, and foment a medical malpractice "revolution." Instead, what has occurred and continues to do so, is the decidely more civil, certainly more politically expedient alternative to revolution — that is, evolution. As defined, evolution is that process of "gradual and relatively peaceful social, political and economic change." It is this evolution over the last ten years that has delivered Representative Art Simon's Malpractice Reform Act of 1985.

Several sessions had to pass before many legislators would even admit there was a malpractice "problem". When confronted with the issue, a common tack was to blame the high insurance premiums and the necessity for defensive medicine on the "bad doctor". Friends in the legislature were blunt. Medicine had an "image" problem. From "bad doctors" to accusations of being interested only in "pocketbook issues", physicians were under attack.

To medicine's credit it learned from its defeats; there was ample opportunity. It listened to friends and studied its detractors. It began to address the problem by becoming more active in the political process. As political awareness increased, issues that affected the quality of life in Florida were addressed and actively supported.

Amendment 9 brought the malpractice issue clearly to the people. For the first time medicine had a statewide forum and an indisputable recognition that a malpractice crisis existed in Florida. Amendment 9 may have failed in the Supreme Court, but not before it left its indelible imprint on the evolutionary process.

Medicine found the 1985 legislative session to be the most receptive in ten years. It enjoyed the support of both House and Senate leadership, which is essential to the passage of any legislation. There was a determination to legislatively address the cry for malpractice reform. While Rep. Art Simon's Malpractice Reform Act is a victory for medicine, it is not a solution to the problem. Rather it must be observed as one more step in the evolutionary process — a step that will move medicine that much closer to its goal, a fair resolution to a crisis that adversely affects the delivery of health care to every citizen in Florida.

Carolyn C. Spore
DeLand
State Legislative Chairman
Florida Medical Association Auxiliary



Rx for fine dining.

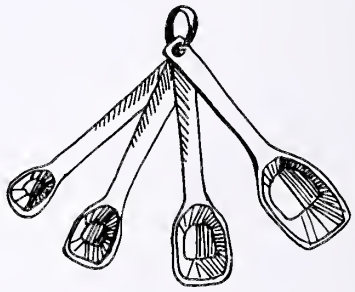
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used.

Mrs. Michael John Murray (Candy)
Lee County

Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

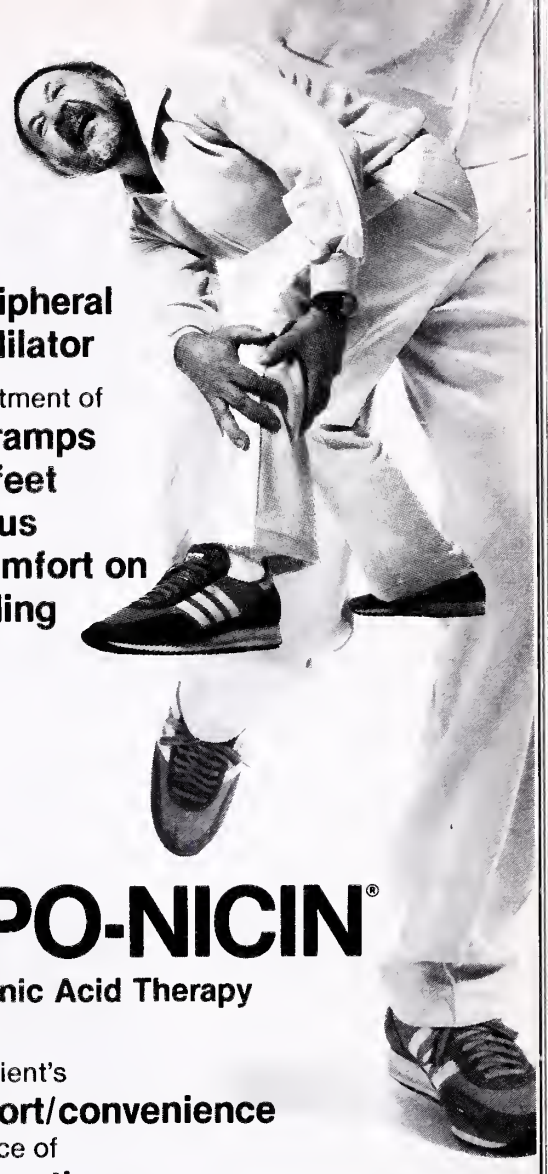
City & State _____

Send the bill for $15.00 (add .75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

AUGUST

Controverises in Carcinoma of the Breast, August 7-10, Hyatt Regency Grand Cypress, Orlando. For more information, contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, 813-974-2538.

Tips, Tricks, Traps and Techniques, August 16-18, Amelia Island Plantation, Amelia Island. For information contact: Beverly Tyson, 655 W. 8th Street, Jacksonville 32209, 904-739-2338.

Arrhythmias: Interpretation, Diagnosis and Management, August 16-18, Orlando Hyatt, Orlando. For information call: Stephen Mattingly, 1-800-421-2323.

SEPTEMBER

Advanced Cardiac LIfe Support, Sept. 13-15, Marion Community Hospital, Ocala. For more information: Marion Community Hospital, Inservice Education Dept., 1431 S.W. First Ave., Ocala, 32671.

Current Concepts in the Diagnosis of Adult Heart Disease IV, Sept. 13-14, New World Inn, Pensacola. For more info call D. Bruce McGraw, M.D., P.O. Box 151, Pensacola, 32591-0151, (904) 478-4121.

International Symposium on Gynecologic Oncology, Surgery and Urology, Sept. 23-27, Germany. For more info: William A. Little, M.D., Deparment of Obstetrics and Gynecology, P.O. Box 016960, Miami 33101, 305-549-6944.

Ninth Annual Medical Aspects of Aging, Septembe 27-28, University of Florida Gainesville. For information call: Grace Wagner, JHMHC J-233, Gainesville 32610, (904 392-3143.

OCTOBER

Eleventh Annual PanAmerican Seminar, Oct. 14-18, Mount Sinai Medical Center, Miami Beach. For more info: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Advanced Neuroradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Ninth Annual Medical Aspects of Aging, October 27-28, University Centre Hospital, Gainesville. For information: James A. Jernigan, M.D., JHMHC-J-233, Gainesville, 32610, 904-392-4321.

Fall 1985 Family Practice Review, October 27-November 2, Orlando. For information: Grace Wagner, JHMHC, J-233, Gainesville 32610 (904) 392-3143.

Fall 1985 Family Practice Review, Oct. 28-Nov. 1, Palace Hotel, Lake Buena Vista. For information: Lamar Crevasse, M.D., JHMHC J-233, Gainesville, 32610, (904) 392-3143.

Clnical Applications for Pulsed, Continuous Color Flow Doppler Echocardiography, Oct.31-Nov. 1, Mount Sinai Medical Center, Miami Beach. For information: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., JHMHC, J-15, Tampa 33612, 813-974-4214.

NOVEMBER

Twenty-sixth Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Hotel, Clearwater. For information: Henry Marriott, M.D., 601 12th Street N., St. Petersburg 33705, (813) 894-0790.

Spinal Deformities, November 3-6, Sheraton Bal Harbour, Bal Harbour. For information: Barry Silverman, 2050 N.E. 163rd Street, N. Miami Beach 33162, (305) 944-4746.

Ninth Annual Seminar: Evolution in the Total Care of the Pediatric Hematology/Oncology Patient, November 21-23, Hyatt Orlando, Orlando. For information: Cindi Butson, P.O. Box 13372, University Station, Gainesville 32604, 904-375-6848.

DECEMBER

Ear, Nose, & Throat Diseases in Children, December 7-11, The Breakers, Palm Beach. For information: 125 DeSoto Street, Piladelphia, PA 15213, 412-647-5466.

Techniques of Therapeutic Endoscopy, December 4-6, Contemporary Resort Hotel, Lake Buena Vista. For info: H. Worth Boyce Jr., M.D., USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612 (813) 974-2034.

Clinical Allergy and Immunology for the Practicing Physician, Dec. 5-7, Palace Hotel, Lake Buena Vista. For info: Richard F. Lockey, M.D., VA Hospital, 13000 N. 30th St., Tampa, 33612, (813) 972-2000, ext.596.

Theoretical and Clinical Considerations Affecting the Selection of Neuroleptic Agents, December 6-7, Boca Raton Hotel, Boca Raton. For information: Millie Toberts, P.O. Box 016960, Miami 33101, 305-549-6327.

American Diabetes Association

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.

CALL TODAY!

Florida Affiliate
(305) 894-6664

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted	☐ Real Estate	☐ Equipment
☐ Situations Wanted	☐ Art	☐ Services
☐ Practices Available		

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication

Physicians Wanted

PRIMARY CARE FACILITY in West Palm Beach seeking part time physicians for hourly work, and full time positions for future facilities. Send CV to: Administrator, P.O. Box 25986, Tamarac, FL 33320.

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE OR EMERGENCY MEDICINE physician opening in a private freestanding emergency center. Excellent location. Highly attractive practice setting. Send CV to: Michael J. Webb, M.D., Harrell Medical Center, 1805 SE Lake Weir Avenue, Ocala, FL 32627 or call (904) 629-0642.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

ANESTHESIOLOGIST with a minimum of eighteen months experience in Pediatric Anesthesia and six months of full-time experience in Cardiothoracic Anesthesia. Must be certified by the American Board of Anesthesiology or equivalent. Clinical and teaching ability. Hours 8-4; annual salary: $85,000; report to Job Service of Florida, 1350 N.W. 12th Ave., room 280, Miami. Refer to job order No.: 4540026.

GENERAL INTERNISTS, PEDIATRICIANS,AND FAMILY PRACTITIONERS: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

PRIMARY CARE CENTERS in Florida: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full-time basis. Positions available in central and south Florida coastal communities. Excellent opportunity - guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 250 N. Babcock St., Suite 202, Melbourne, Florida 32935.

RESIDENCY DIRECTOR: University Hospital of Jacksonville, a large non-profit teaching hospital, is seeking a physician with residency and administrative experience to lead new Family Practice Residency. Competitive salary and excellent fringe benefits. Send C.V. to John A. Grisnik, Jr., M.D., Department of Community Health and Family Medicine, University Hospital of Jacksonville, 655 West 8th Street, Jacksonville, Florida 32209.

COME TO PARADISE: Rewarding primary care practice in Key West, Florida. Join the Island Clinic Group. Phone 305-294-4657. Ask for John Buckner.

EXPERIENCED, BOARD CERTIFIED SPECIALISTS in orthopedics, neurosurgery/neurology, and EMG wanted for part time association with office based group performing medico-legal evaluations in Dade and Broward Counties. We offer excellent renumeration with no nights or weekends on call, and minimal malpractice exposure. Call (305) 557-0900 or send C.V. to Medical Director, Southern Diagnostic Associates, Inc., 1575 West 49th Street, Suite 132, Hialeah, Florida 33012.

PRIMARY CARE PHYSICIANS to associate with Free Standing Walk-In Center, some ER experience helpful. Please send CV or contact Jensen Beach Emergi-Centre, 1801 NE Commercial Street, Jensen Beach, Fl 33457, (305) 334-1700.

ANTERIOR SEGMENT FELLOWSHIP in busy private practice associated with medical college. Intraocular lens implantation, including posterior chamber and anterior chamber lenses. Extracapsular and Phacoemulsification techniques. Argon and Yag Laser. Excellent benefits plus fringes. Send CV and career objectives to: C-1242, P.O. Box 2411, Jacksonville, FL 32203.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

FAMILY PHYSICIAN TO JOIN busy internist in Florida Keys. Office has laboratory, EKG and X-ray capabilities. Will provide very flexible association to the right individual. Send CV to: Robert Carraway, M.D., P.O. Box 2008, Key West, FL 33040 (305) 294-0511.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

WANTED — INTERNIST with interest in cardiology or rheumatology. Opportunity available in beautiful lakes and hills of Central Florida, 25 miles north of Orlando. In established fully equipped clinic, lease with later option to buy. Close to 150 bed hospital which will guarantee adequate income first year. C-1270, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPAEDIC SURGEON — wanted to join an established surgeon, southeast Florida, Boynton Beach area. Send CV: C-1279, P.O. Box 2411, Jacksonville, Fl. 32203.

WANTED: IM, FP, OR GP to share furnished and fully equipped office building with General Surgeon, Orthopaedic Surgeon, Family Practitioner and Gynecologist. Location established 35 years. Adjacent to major hospital diagnostic center in North Miami, Florida. Facilities include X-Ray, Minor Surgery, EKG, computerized billing and insurance. Send CV to office manager, 12996 W. Dixie Hwy., N. Miami, Fl 33161, (305) 891-6589.

POSSIBLE OPENING FOR UROLOGIST. Established practice in Naples, Fl. All you need in one package. Call (813) 262-3996 or (813) 262-1521 for further information.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

PHYSICIANS: Progressive, physician-owned medical group has positions available in the SE Florida area. Experienced, Board-prepared or Board certified physicians are preferred with interests in primary care, internal medicine, emergency and critical care medicine. Competitive salary, fringe benefits, paid malpractice insurance. Call (305) 325-1381 or send CV to Emergency Medical Group, P.A., 1400 NW 12 Ave., Miami, FL 33136.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

ST. PETERSBURG: Opportunity for experienced emerging physician in low-volume E.D. on Florida's Gulf Coast. ACLS essential, ATLS encouraged. Send C.V. to S. MacLeod, M.D., 8601 Merrimoor Blvd., E., Largo, FL 33543, or call 813/397-7234.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

FAMILY PHYSICIAN, Board certified, to join a well established solo practice in Central Florida. Initial salary with early opportunity for partnership. For further information, please call (813) 859-2748.

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

WORKING MEDICAL DIRECTOR wanted for outpatient walk-in center. Private practice opportunity on Florida Gulf Coast. Available immediately. Financial renumeration based on % of gross receipts. Respond with resume including phone number to Medical Clinic, P.O. Box 25312, Tampa, Fl 33622.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only.

EMERGENCY MEDICINE/URGENT CARE CENTERS — We have several attractive opportunities available in hospital based emergency rooms, and free standing urgent care centers in Florida, Georgia and Alabama. We seek U.S.-trained, board certified/board eligible EM/IM/FP experienced physicians. Malpractice and competitive salary offered. Low to moderate volume and flexible scheduling. Send C.V. to J.M. Garner, M.D., Dept. J, 890 S.R. 434 North, Altamonte Springs, Fl. 32714 or call Sandy Teal, 305-788-0786.

FAMILY PRACTICE Physician with good experience in emergency medicine needed along S.E. Florida coast. Send resume to: C.P. Viado, M.D., 805 Virginia Avenue, Suite 11, Ft. Pierce, FL 33482.

PSYCHIATRIST — full-time position open for board certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient only. Florida license needed. Write or call: A. Mullin, M.D., Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Avenue, Jacksonville, Fl. 32204, Phone (904) 384-2364.

OPHTHALMOLOGIST, BC/BE, to join very busy solo ophthalmologist. North Central Florida. Good hunting, fishing, boating, near ocean. Industrial, tourist, retirement area. Could gradually assume practice as Senior Partner slows down. Contact: P.O. Box 17038, Jacksonville, Fl. 32216.

Situations Wanted

BOARD CERTIFIED PEDIATRICIAN, Florida licensed, seeks group practice in Florida. C-1227, P.O. Box 2411, Jacksonville, Fl 32203.

ANESTHESIOLOGIST: 36, Florida licensed, in process of ABA Certification, Fellowship in Pain Management, group practice last two years, extensive experience in Regional Anesthesia, desires to settle in Florida, consider any opportunity, Available anytime. Reply: Dharia, M.D., 67-02 230th St., Bayside, N.Y., 11364, 718-225-5804.

LOCUM-TENENS work wanted in primary care facility, or office practice. Coverage provided by licensed and insured physicians. Radiologists also available. Call 1-800-545-4141, Ext. 257.

LOCUM-TENENS: Radiologist, Board Certified, 53, academic and administrative experience, does most modalities, will also consider permanent association. Please write Box C-1265, P.O. Box 2411, Jacksonville, Fl. 32203.

BOARD CERTIFIED INTERNIST, Florida licensed, looking to join solo or group primary care practice on east coast. Available immediately. Reply: Charles Gelfman, 123-33 83rd Ave., Apt. 1605, Kew Gardens, N.Y. 11415 or call evenings (718) 544-9662.

Practices Available

INTERNAL-MED, FAMILY Practice est. 30 years for sale. Eager to retire. No reasonable offer refused. No cash needed for physician just completing residency. Five local hospitals require Board Eligible. Write Medical Center, P.O. Box 7603, West Palm Beach, FL 33405.

INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

OTOLARYNGOLOGY practice, established 27 years. Patients records, equipment and office available. Price negotiable. Otolaryngologist, Suite E, 500 Memorial Circle, Ormond Beach, FL 32074.

UROLOGIC PRACTICE FOR SALE. N. Central Florida. Have just retired. Same location over thirty years. Office equipment for sale. Lovely two-man urologic building adjacent to local hospital also for sale. Florida license is essential. Reply Box C-1273, P.O. Box 2411, Jacksonville, FL 32203.

PEDIATRICS — North Fl., well established, fully equipped, centrally located, hospitals nearby, good clientele, quality practice, charts, equipment, goodwill transferable; office building for purchase or rent, terms flexible, BE/BC, contact C-1275, P.O. Box 2411, Jacksonville, FL 32203.

OPHTHALMOLOGY PRACTICE for sale — Location: Northeast Florida. Gross $500,000±, potential move, room for two. Building 4200 sq. ft. over 20 exam, treatment work rooms, busy optical shop. One-half acre corner lot. Hospital one-half mile. Contact C-1276, P.O. Box 2411, Jacksonville, Fl. 32203.

CENTRAL FLORIDA. 30-year busy B.C. family practice. Two-man building/land. Need associate, B.C., share expenses, to introduce into practice. Ultimately lease or purchase. C-1280, P.O. Box 2411, Jacksonville, Fl. 32203.

UROLOGICAL PRACTICE: office and equipment in S.W. Florida. (813) 262-3996.

Real Estate

DECORATED OFFICE SPACE AVAILABLE in the beautiful Lighthouse Point Professional Building at 2211 NE 36 Street, Lighthouse Point, Florida. For details please call (305) 942-1444.

GREAT OPPORTUNITY: Active Delray Beach Medical Building — 1800 sq. ft. available. $13.00 sq. ft. will divide. Lg. Internal Medical group ground floor. 305-272-7428. Ask for Jan.

GAINESVILLE, Bellamy Forge, 3 BR, 2½ B, attached garage, condo with all amenities, mint condition, $56,500.00. (813)254-3412.

MUST SELL: Beautiful condominium Palm Beach area. Two baths, two bedrooms. Pool private sun deck. Contact P.O. Box 2914, Winter Park, 32790.

SOUTH MIAMI MEDICAL ARTS BUILDING: All specialties. Adjacent to two hospitals. 1500 - 1800 sq.ft. Fully partitioned and carpeted. Reasonable rent. (305) 661-5147.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned medical instrumentation: EKG, Lab, Holter, scanners, 2 D. Echos, stress-test, etc. Contact: Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065, 305-972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write: Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2, Box 386 A, Adel, Georgia. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

HOLTER SCANNING AND INTERPRETATION nationwide. For offices or hospitals at very special rates. Includes cardiology interpretation, immediate phone reporting, etc. Special rates for hospitals, HMO's. Will provide recorder and arrange for your office to learn patient connection, quality, etc. For information call Pittsburgh Cardiovascular, (412) 372-2035. 2550 Mosside Boulevard, Monroeville, PA 15146.

Equipment

COMPLETE RADIOGRAPHIC Fluoroscopic X-ray room with 10 y.o. Picker 90/15 table. Morror optics and precise optics T.V. system included. The image intensifer, fluoroscopic X-ray tube and automatic brightness system are only one year old. Call Kissimmee Memorial Hospital (305) 846-4343, Ext. 387 for Dr. Sessions or Dr. Mayo.

Meetings

THE THIRD ANNUAL ADVANCED NEURORADIOLOGY SEMINAR sponsored by the Departments of Radiology at the University of South Florida College of Medicine and Tampa General Hospital will be held in the Walt Disney World Village Hilton, October 16-19, 1985. The course will stress the more recent advances in NMR, CAT Scanning and Interventional Neuroradiology. Guest faculty will include Drs. Bradley, Daniels, Fitz, Hachinski, Michelsen, Modic and Vinuela. The fee is $340 for 16 Category I Credit hours. Call Charleen Kirissman 813/974-2538 for more information.

WE'RE YOUR PUBLIC LIBRARY

It's OK to get SMART with US!

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

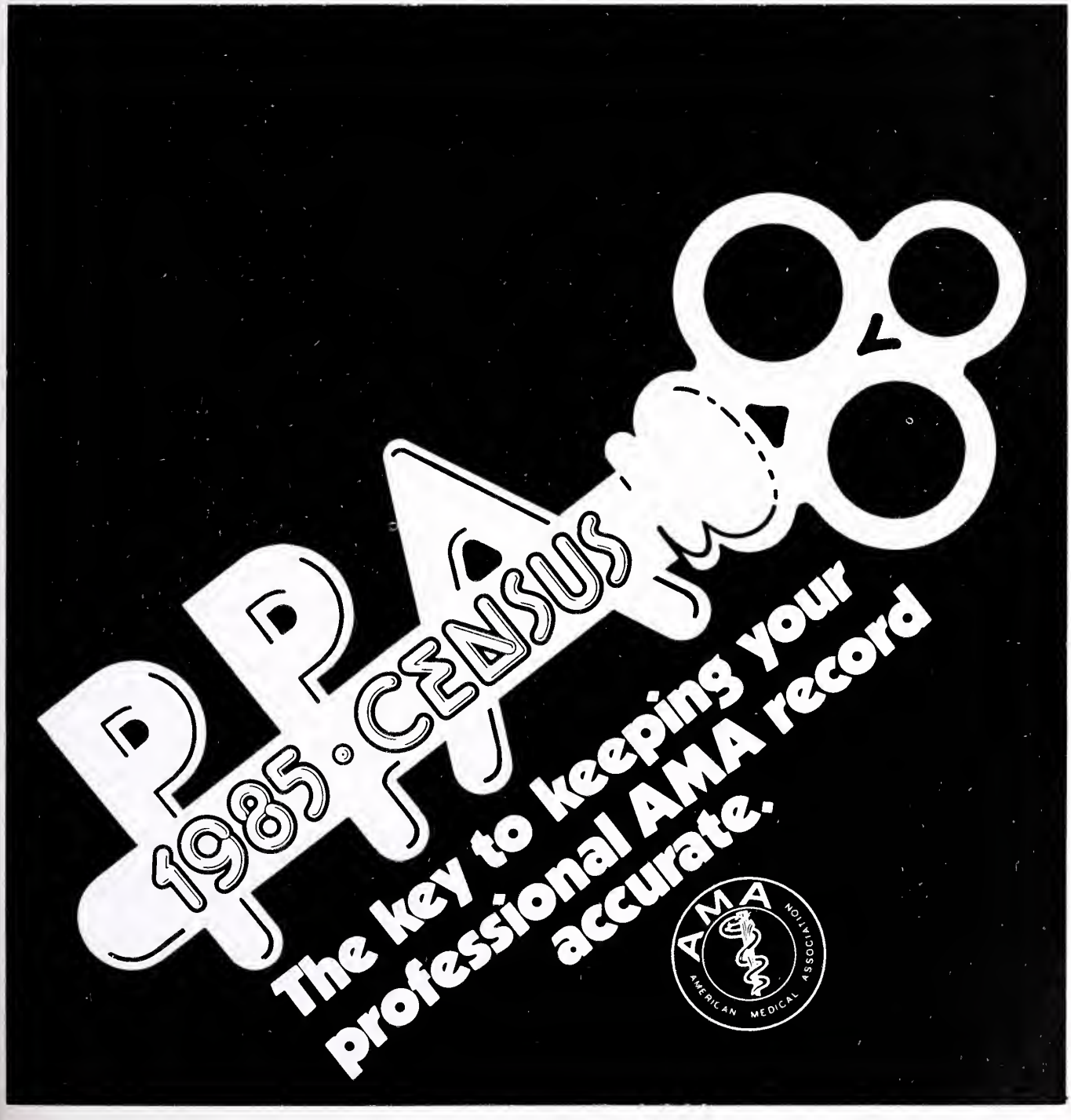
Physicians!
Plan to Participate When Your Census Form Arrives

Completing and mailing in your Physicians' Professional Activities Census form will ensure:

- That your professional record is updated on the AMA Physician Masterfile;
- That you are correctly classified by specialty and activity in the AMERICAN MEDICAL DIRECTORY;
- That you continue to receive educational and scientific materials relevant to your professional interests.

Call or write if you have not received a census form by April 1985:

Division of Survey & Data Resources
American Medical Association
535 North Dearborn Street
Chicago, IL 60610
(312) 645-5136



ADVERTISERS

Air Force
Recruitment 494

Army Reserve
Recruitment 514

Ayerst Laboratories
Inderal LA 526b

BellSouth Mobility
Service 515

Brookwood Recovery Centers
Service 481

Brown Pharmaceutical
Android 494
Lipo-Nicin 551

Curtis 1000 Information Systems
Computers 488

Eli Lilly & Company
Keflex 548

Florida Physicians' Insurance Reciprocal
Service 478

GTE Telenet
Service 484

Janssen Pharmaceutica
Vermox 543

Marion Laboratories, Inc.
Cardizem 478c

Parke-Davis
Norlestrin 494a

Roche
Dalmane 560

Southeastern Medical Data Systems
Service 547

University of Miami
Meetings 516

The Upjohn Company
Motrin 526a

Willingway Hospital
Service 531

Wyeth Laboratories
Ativan 479

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Director and C.E.O.

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

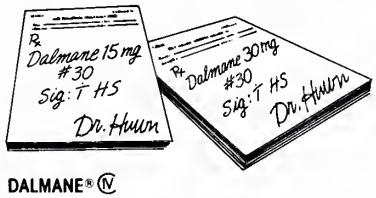
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche
sleep that satisfies

15-mg/30-mg capsules



References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Phormocol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Phormacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Phormocol Ther 32*:781-788, Dec 1982. **5.** Frast JD Jr, DeLucchi MR: *J Am Geriotr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behov Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychophormocol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Sympasium an the Treatment af Sleep Disarders, Telecanference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Phormacol Ther 21*:355-361, Mar 1977.



DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

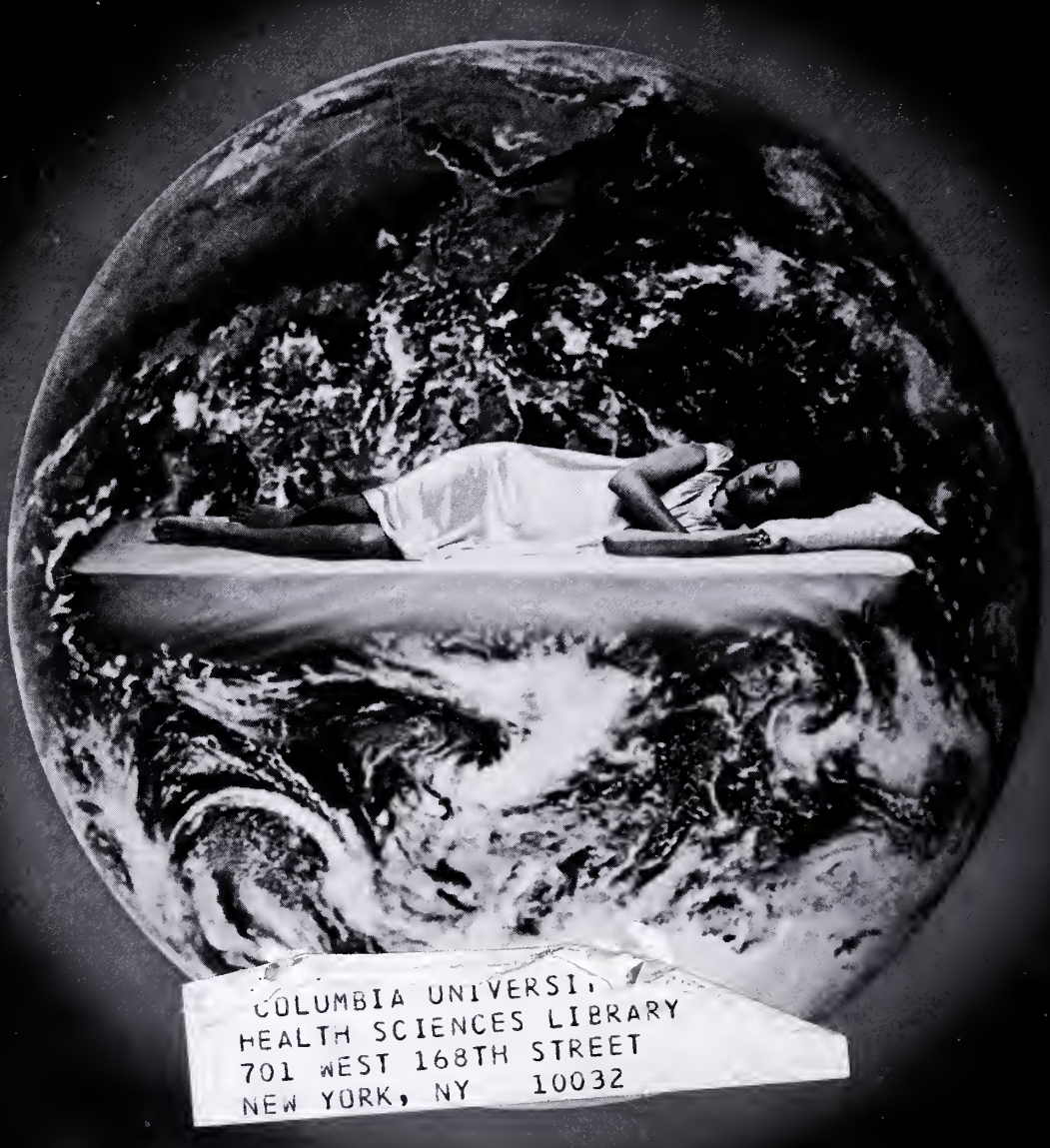
#1 IN EXPERIENCE

Worldwide, it's a known quantity... known for sleep that satisfies.

You know it helps patients fall asleep quickly and stay asleep till morning.[1-8] You know its exceptionally wide margin of safety.[7-9] You know it better than any other hypnotic. The *only* benzodiazepine hypnotic with more than 15 years of continuing satisfactory performance. As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE® Ⓒ
flurazepam HCl/Roche
sleep that satisfies



COLUMBIA UNIVERSI
HEALTH SCIENCES LIBRARY
701 WEST 168TH STREET
NEW YORK, NY 10032

ROCHE®

Copyright © 1985 by Roche Products Inc. All rights reserved.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. August 1985 Vol. 72, No. 8

PROCEEDINGS ISSUE



CURRENT
COLUMBIA UNIVERSITY
SEP 09 1985
HEALTH SCIENCES
LIBRARY

STABILITY

WE'LL BE HERE WHEN YOU NEED US

* Compare your Reciprocal's Quality, Stability and Accessibility when a claim arises.
* Total assets of $67 million; surplus of $6 million; current annualized premiums of more than $23 million.
* Superior protection; appropiate rate levels; many features responsive to the specific coverage needs of Florida physicians.
* Non-assessable policy for your future protection.



For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Board of Governors
OF THE
FLORIDA MEDICAL ASSOCIATION
P.O. BOX 2411 - JACKSONVILLE, FLORIDA 32203

DONALD C. JONES, Executive Vice President

*LUIS M. PEREZ, M.D., President
*JAMES B. PERRY, M.D., Pres. Elect
*JAMES G. WHITE, M.D., Vice President
*HENRY M. YONGE, M.D., Secretary
*YANK D. COBLE JR., M.D., Treasurer
*FRANK C. COLEMAN, M.D., IPP-87
J. LEE DOCKERY, M.D., PP-86
GUY T. SELANDER, M.D., Speaker of the House
CHARLES K. DONEGAN, M.D., AMA Del. 86
CHARLES B. McINTOSH, M.D., AL-86
GEROLD L. SCHIEBLER, M.D., A-86
*KAY K. HANLEY, M.D., B-87
DICK L. VAN ELDIK, M.D., C-89
A. FREDERICK SCHILD, M.D., D-88
ROBERT N. WEBSTER, M.D., SBME-86
EUGENE G. PEEK JR., M.D., HRS-86
MISS JANE A. DANIEL, Student Member-87

* Executive Committee

Summary of the FMA Board of Governors Meeting June 29, 1985

The following is a summary of the major actions taken by the Board of Governors at its meeting June 29, 1985.

THE BOARD:

Future PLI Efforts

Approved the following policy in respect to future PLI activities of the Association:

The Board of Governors expressed support for any one or all of the following elements for additional tort reform during the 1986 Legislative Session:

- Elimination of joint and several liability
- Elimination of mandatory insurance for physicians
- Cap on general damages (non-economic)
- Removal of the resolution of professional liability cases from the tort system

The Board further approved the following overall policy in respect to the professional liability issue:

- That FMA staff be directed to study and evaluate the proposal for removal of the resolution of professional liability cases from the tort system and report its evaluation to the Board of Governors.
- That FMA will continue to review the effectiveness of the Comprehensive Medical Malpractice Reform Act of 1985 and seek any appropriate and feasible changes during the 1986 Legislative Session.
- That FMA continue to explore with other organizations identification of appropriate issues and support for those issues in respect to a constitutional initiative.

Programs and Priorities 1985-86

Approved in principle the proposed FMA programs and priorities for 1985-86 subject to review and input by component medical societies and final consideration by the Board of Governors at its October meeting. (Attachment)

Statewide IPA Study

Approved an immediate study by FMA in respect to the feasibility of the Association seeking to establish an FMA sponsored statewide prepaid health care plan.

Candidates for AMA Elective Office

Enthusiastically endorsed the candidacy of Rufus K. Broadaway, M.D., for President-Elect of the American Medical Association and J. Lee Dockery, M.D., for reelection to the Council on Medical Education of the American Medical Association at the 1986 AMA Annual Meeting and approved appropriate funding for campaign expenses from Association resources and other sources to be identified.

1986 Annual Meeting Dates

Established September 17-20, 1986 as the dates for the 1986 FMA Annual Meeting and further selected the Diplomat Hotel as the site of the 1986 Annual Meeting due to more favorable contractual arrangements.

Attendance at Board of Governors Meetings

Approved advising county medical society presidents and executive directors that they are welcome to attend, at their own expense, all Board of Governors' meetings, including the Fall Meeting.

Medical/Legal Hotline

Approved guidelines for the implementation of the FMA Medical/Legal Hotline to be established effective July 1, 1985.

Medical Practice Act Licensure Exemption Law

Authorized the President and FMA Legal Counsel to explore the constitutional aspects of the Licensure Exemption Law passed during the 1985 Legislature.

COUNCILS AND COMMITTEES

The Board reviewed reports and recommendations from FMA Councils and Committees and took the following actions:

Non-PLI Legislative Priorities

Approved the following non-professional liability legislative priorities for the FMA for the 1986 Session, and authorized staff to begin appropriate review of these issues and develop recommended policy and support information on each issue prior to the October 1985 Board of Governors Meeting.

- Sunset review of the Medical Practice Act
- Sunset review of Allied Health Professionals
- Certificate of Need
- Designation of trauma centers
- Indigent health care funding
- Reorganization of the Department of Health and Rehabilitative Services (DHRS)
- Foreign Medical Graduates
- The Law of Medicine

COUNCIL ON HOSPITAL MEDICAL STAFFS

Council Appointments

Approved appointment of the following individuals from each FMA medical district to serve on the Council on Hospital Medical Staffs.

District A - North Medical

Richard W. Cunningham, M.D., Alachua County
Robert P. Johnson, M.D., Capital

District B - West Medical

Marc Freeman, M.D., Pasco County
Ray Barnes, M.D., Polk County

District C - East Medical

Richard W. Snodgrass, M.D., Volusia County
Leonard Erdman, M.D., Broward County

District D - South Medical

Joseph Harris, M.D., Dade County
Esteban Valdes-Castillo, M.D., Dade County

Risk Management Committee

Approved the following nominations for appointment to the Risk Management Committee of the Council on Hospital Medical Staffs:

Charles P. Gibbs, M.D.
Eric Geiger, M.D.
Francis L. Howington, M.D.
Howard A. Hogshead, M.D.
Paul Gluck, M.D.
Herbert Aronson, M.D.

Mandatory Insurance

Approved referral to the President and to Legal Counsel for determination of the appropriate Association action regarding the issue of the mandatory insurance coverage requirement that is being mandated by certain medical malpractice insurers in the state who are requiring physicians with hospital privileges to maintain $1 million in malpractice coverage as a condition of insuring the hospital.

COUNCIL ON MEDICAL SERVICES

Drug Education Performance Standards K-12

Approved the recommendation that the Florida Medical Association endorse the Florida Alcohol and Drug Abuse Association's "Drug Education Performance Standards K-12"; and further approved that FMA urge the Florida Department of Education to use this booklet in planning curriculum for kindergarten to grade 12 subject to review and approval by the Council on Scientific Activities.

COUNCIL ON MEDICAL ECONOMICS

Professional Foundation for Health Care

Authorized the FMA to establish liaison with the Professional Foundation for Health Care, Inc. (PFHC), in order to develop a mechanism to effectively address problems which have been created by the present statewide PRO.

Council on Hospital Medical Staffs

Approved the recommendation to request the Council on Hospital Medical Staffs to invite representatives from each hospital in the state to notify the Council of any problems they have encountered with the PRO for their review, study and forwarding of this information to the Committee on PRO for their review and action.

Certificate of Need

Approved the recommendation that the Statewide Health Council be requested to include physician representation from nominees recommended by the FMA to participate in the Certificate of Need Task Force proposed by the Statewide Health Council.

COUNCIL ON SCIENTIFIC ACTIVITIES

Mandatory Continuing Medical Education

The Board was advised that the Chairman of the Council on Scientific Activities was in the process of establishing contact and liaison with the Department of Professional Regulation for the purpose of beginning dialogue in respect to the recently adopted legislation which requires at least sixty hours of continuing medical education every three years for physicians.

JUDICIAL COUNCIL

Physician Discipline and Fee Disputes

Authorized the President of the FMA to appoint an ad hoc committee of the Judicial Council to study the need for changes in the handling of grievances against members and the establishment of a streamlined procedure for handling other complaints and fee disputes and that the committee be charged with making specific policy recommendations to the Board.

COMMITTEE ON IMPAIRED PHYSICIANS

Appointment of Advisory Member to IPC

Approved the selection of Larry Gore, DVM, CAE, of Orlando, Executive Vice President of the Florida Veterinary Medical Association as an advisory member of the Committee on Impaired Physicians.

FLORIDA PHYSICIANS ASSOCIATION

Newly Elected Officers

Received an informational report from the Florida Physicians Association in respect to newly elected officers. The following were elected:

Charles J. Kahn, M.D., President
John A. Dyal Jr., M.D., Vice President
Miguel Figueroa, M.D., Secretary
Warren M. Barrett, M.D., Treasurer

Collective Bargaining

Received a report that the FPA is investigating the legalities affecting the FPA in serving as a third party collective bargaining agent for the Association's members.

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

PLI Voting Records

The Board received an informational report in respect to FLAMPAC membership and the 1985 professional liability voting records. The Board was advised that a two-day meeting of the FLAMPAC Board of Directors will be held July 26 and 27, at which time FLAMPAC will begin targeting 1986 campaigns and approving programs for the coming year.

REPORT OF PUBLIC RELATIONS OFFICER

Future Activities

The Board received an in-depth report from the Public Relations Officer on current, short-term and long-range public relations activities of the Association. A broad-based and ongoing public relations program is being developed and will require a major long-term commitment by the Association in both time and financial resources. Moreover, it will only be successful if it is properly coordinated with the AMA (see item re AMA public awareness campaign) and FMA component medical societies and specialty groups and, perhaps most important, if individual physicians are willing to participate as an integral element of any program. The program must begin and end in the physician's office or his/her contact with people in any setting. The most effective public relations comes from the grassroots level. Physicians must become more aware of their individual image, particularly in the area of patient relationships. If physicians are alienating their patients, our public relations program will be facing an uphill battle. Therefore, a top priority will be to develop training programs in patient relations for physicians and their office staffs.

Efforts will be made to organize a panel of physicians from differing specialties to discuss patient relationships and varying problems of the office practice and physician/patient relationship. If the major real or perceived problem areas can be identified, we will be better equipped to design a more effective educational or behavioral-type program.

Some preliminary ideas as to the methods of developing a patient relations training program for physicians include:

- A program for either the next Leadership Conference or Annual Meeting
- Develop a program which the county medical societies could administer
- Develop periodic columns on the subject for the Association's monthly newsletter, *FMA Today*, and *The Journal* of the FMA

Another potential area for development at the grassroots level is communicating messages to patients in the physician's office waiting room. The FMA is exploring the possibility and feasibility of initiating a mechanism whereby physicians could, at a reasonable cost, install VCRs in their waiting rooms. These would be used to show a variety of medical programming or medical-related issues to patients waiting to see their physician. The FMA would develop programs for video taping as well as use existing materials. This is a long-range project which will require in-depth study and investigation before implementation.

Another area of activity is the publishing of a quarterly newsletter targeted for state legislators and the Congressional Delegation and other selected government officials. Through

this newsletter, FMA would seek to keep legislators and government administrators updated and informed about medical issues impacting physicians and the general public.

Developing speakers bureaus at the county medical society level is an important priority as well as developing some young, dynamic physicians to be spokespersons. The FMA will work with the AMA Communications Department to develop a mechanism for conducting speaker's training courses in Florida on an ongoing basis.

AMA DELEGATION

The Board received a report from the Chairman of the AMA Delegation in respect to the delegation activities during the 1985 AMA Annual Meeting June 16-20 and the actions of the House of Delegates. The House considered approximately 155 resolutions from constituent state medical associations and national specialty groups as well as numerous reports from the Board of Trustees and AMA Councils. The following is a summary of the major actions of the House. A more complete report will be included in *AM NEWS* and future FMA newsletters to the membership.

Medicare Program

Report EE of the Board of Trustees was a brief report on studies of fiscal stability of Medicare, which informed the House that it is studying development of a Health IRA proposal to improve the program's financial soundness. Resolution 16, "Health Individual Reserve Accounts" (H-IRA) and Resolution 89, "Endorsement of IRAs", both call for the conditional support by the Association of Health-IRAs. The House adopted these Resolutions.

Resolution 18, "Direct Provided Payment for all Medicare Medical Services" was adopted by the House. This Resolution asks that the Association seek direct payment to providers by Medicare whether or not the provider accepts assignment. There was considerable debate on this Resolution because it would require a change in the law, not merely in regulations.

Resolution 38, "Capitation Programs for Medicare Recipients" was adopted. This Resolution calls for regulations which would require Health Maintenance Organizations and Competitive Medical Plans to fully explain ramifications of membership to Medicare eligibles and for HRS to verify performance capabilities of such plans before awarding them contracts.

The House adopted Substitute Resolution 110 which concerns Medicare payments. The Resolution states:

RESOLVED, That the American Medical Association requests that the Health Care Financing Administration direct Medicare carriers in each state to reevaluate the data and methodology used in calculating customary profiles in the local prevailing fee screens for all physicians, and that three customary charge profiles be made available promptly to each physician, when requested, for review and verification, and be it further

RESOLVED, That the American Medical Association continue its opposition to the limitations on increases in the customary and prevailing charge levels for Medicare reimbursement and its opposition to the freeze on actual fees for services provided Medicare beneficiaries.

Health Care Funding for the Financially Disadvantaged

Report A of the Council on Medical Service entitled "Closing the Gaps in Health Care Funding" was adopted by the House. This is a detailed report on the amount of uncompensated care provided by physicians, the types and estimated number of patients receiving such care, and potential solutions. It was further recommended that this report receive wide dissemination, especially through AMA media sources. This is a subject of critical importance that requires continued study and future reports regarding the issues of financing coverage and availability of adequate health expense coverage.

Professional Liability

The House approved two reports on the Association's activities in Professional Liability. Report 00 is a report by the Committee on Professional Liability on its study of professional liability plaguing obstetricians and gynecologists and Florida physicians in recognition that both groups are facing a special crisis involving both affordability and availability of professional liability coverage.

Report AA details the program of the Association's Special Task Force on Professional Liability and Insurance, highlighting the Action Plan developed by the Task Force and many activities undertaken in implementation of the Action Plan to date.

Two other Resolutions were adopted by the House concerning the malpractice crisis. Resolution 149, entitled "Malpractice Crisis" directs the AMA Board of Trustees to urge the Special Task Force on Professional Liability and Insurance to consider all means to inform the general public concerning the

malpractice crisis. It also urged an AMA appeal to the Federal Government and local medical society appeals to state legislators and governors, to propose solutions to the professional liability situation.

Resolution 155, entitled "Liability Media Campaign", directs the AMA immediately to begin preparation of an expanded and more specific response to the American Trial Lawyers Association's contentions regarding the current situation in professional liability and to make the resulting rebuttal to ATLA contentions available for use by advocates of tort reform to counter and dispel ATLA's arguments before the public. The Resolution was amended to reflect the fact that the Association has already begun developing a response to the ATLA's agruments.

Medical Staff Section

The Hospital Staff Section submitted 13 Resolutions to the House of Delegates concerning physician/hospital relations. Of these 13 Resolutions, 7 were adopted, 3 will be addressed at the Interim 1985 Meeting, 2 were referred to the Board of Trustees, and 1 was not adopted.

Following are the Resolutions which were adopted:

Resolution 149 - Malpractice Prices

Resolution 152 - Support for Inner-City Hospitals

Resolution 150 - Guidelines for Outpatient Surgery and Same Day Admission

Resolution 151 - Physicians Statement on the Federal DRG Program

Resolution 147 - Hospital Administrator and Medical Executive Committees

Resolution 153 - The Report of the Joint Task Force on Hospital Medical Staffs Relations

Resolution 145 - Utilization Peer Review

Alternative Delivery System

The House of Delegates considered and adopted several Resolutions relating to Alternative Delivery Systems including Resolution 54 presented by the Florida Delegation. This Resolution was combined into Substitute Resolution 43. It calls for legislation to revise federal policies so that employees must make traditional fee-for-service coverage as an option to employees whenever employers are mandated by law to offer an HMO option for health care services.

The House also adopted Resolution 90, "Medical Society Sponsorship of Statewide IPA/HMO". This Resolution calls for the AMA to monitor the Medical Association of Georgia Independent Practice Association/HMO Plan and determine if its widespread use would be beneficial. The House also reaffirms support for the indemnity payment system and to seek immediate implementation of it at the national level.

Peer Review Organizations

Report H of the Council on Medical Service reported on the status of the Peer Review Organization (PRO) Program. The Council concluded that the current Association policy on Peer Review remains appropriate but that it should be continually reassessed in light of new developments in the PRO Program. Testimony received also indicated some specific problems with the PRO Program, such as some PRO's establishment of standards of care in medical protocols without the appropriate involvement of practicing physicians. These matters will be included in future Council studies. Resolution 105, "PRO Appeals Process" was adopted by the House. This Resolution favors changing federal legislation to allow physicians access to an administrative hearing or judicial review of an unfavorable reconsidered decision by a PRO.

Alcohol and The Driver

Report A of the Council on Scientific Affairs described the Council's study of alcohol and drivers, recommending among other things an AMA program including public information against drinking by drivers; support of legislation establishing a 0.05% blood-alcohol level as conclusive evidence of drunk driving; supporting 21 as the legal drinking age; supporting state legislation calling for administrative suspension or revocation of drivers' licenses after driving under the influence; and encouraging industry efforts to develop a safety mechanism that thwarts operation of a car by an intoxicated person.

Public Awareness Program

At the Interim Meeting, the AMA's House of Delegates adopted Report 00 of the Board of Trustees and Substitute Resolution 2. These actions call for the Association to develop a wide range of activities aimed at informing the public of changes in the Medical Care Delivery System and increasing the public's awareness that physicians are their patients best advocate in safeguarding the quality of medical care in the United States.

Report RR of the Board of Trustees presents a five-point program which has been developed by staff working closely with nationally recognized experts. The funding of projects included is based on a major redirection of current Association activities. The program, to be implemented in 1985, is designed to

strengthen and reinforce but not substitute for the Association's long standing communications activities.

This program reflects two fundamental considerations — the need to:

- monitor and evaluate each project on a limited market basis because of the lack of research on the relative effectiveness of different strategies.
- target each activity to the state and county level for maximum federation involvement and impact.

Elements of the five-point program include:

State Surveys for Program Evaluations

The AMA will conduct base-line surveys on the public's views toward medicine and physicians in all 50 states.

Production and Evaluation of Television Infomercials

The AMA has been for a number of years very successful in producing and obtaining TV air time for its award-winning public service announcements (PSAs). Recently, a number of not-for-profit associations has begun to explore purchased air time as a more direct way of communicating with the public. In this regard, the informational commercial, or infomercial, is gaining popularity. The AMA will produce one infomercial with the content emphasizing the impact of changes in the medical care system and the vital role that physicians play as advocates for their patients. Following production, the infomercial will be aired during prime time in a test market for approximately 10 days.

Promotion and Distribution of Physician Profile Film

The AMA has completed production of a documentary/drama on physicians and the current practice of medicine. Profiles of physicians in a variety of professional and geographic settings have been included. The primary focus is on the many changes that are occurring in American medicine today and how physicians serve as caring advocates of their patients' rights.

This film will also be test marketed before general release. Public distribution will be through a theatrical release package developed and coordinated by an external booking agency. Outlets are primarily theatres, but can also include cable and satellite television link-ups.

Public Health Campaign Pilot

To increase public visibility for local and state associations, the AMA will provide several state and county societies with the basic framework necessary to conduct the pilot Public Health Campaign. The local society will sponsor an extended event, based on the public health theme, which will involve community action, physician participation, and public service.

National Communications Workshop

There is widespread agreement that the success of any public relations image program depends upon a local, as opposed to a national, focus. For this reason, the communications/public relations staff and activities of the Federation constitute a major resource for both planning and implementing an ongoing awareness program.

To effectively mobilize this resource, staff from the Federation will meet for an annual communications forum in Chicago. The meeting will address communications problems and successes in a broad range of areas. Opportunity will exist for communications education sessions on spokesmanship training, "Training the Trainers," building media relations, and other issues.

The National Communications Workshop will consist of a 1½ day session held in Chicago during October on an annual basis.

AMA Trustees Elected

The Delegation was delighted to report the election of Rufus K. Broadaway, M.D., for a second three-year term as a member of the Board of Trustees of the American Medical Association. The delegation has expressed its full support for Dr. Broadaway's candidacy for the Office of President-Elect of the AMA at the 1986 Annual Meeting.

Nominations

The Board of Governors also enthusiastically endorsed the nomination of Frank C. Coleman, M.D., to the AMA Task Force on Professional Liability and Louis C. Murray, M.D., to the Council on Legislation.

Dues Increase

The Board was advised that the AMA House of Delegates approved a $45 a year dues increase to become effective January 1, 1986. The increase will establish a dues level of $375 for regular members.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

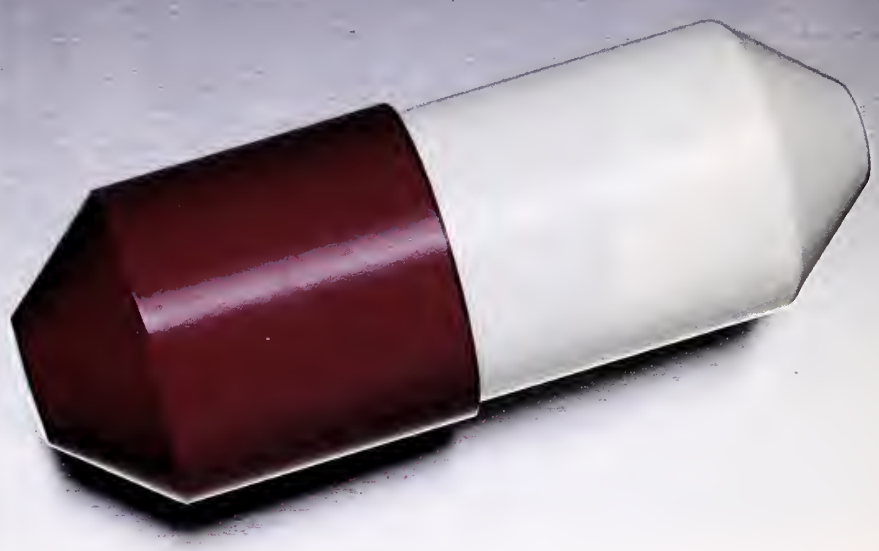
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (Intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983

Help her compute America's future.



Today, our children are computing basic math. Tomorrow, they'll be programming the future.

But before they can fill the computer screen with new information, we'll have to help fill their minds. With ideas. Information. Dreams. With the stimulation only a first-rate college education can provide.

But they'll need your help.

Because only with your help will colleges be able to cope with the high cost of learning.

Rising costs and shrinking revenues are threatening the ability of colleges to provide the kind of education tomorrow's leaders will need to solve tomorrow's problems.

So please give generously to the college of your choice.

You'll be programming America for success for years to come.

Give to the college of your choice.

COUNCIL FOR FINANCIAL AID TO EDUCATION, INC.
680 FIFTH AVENUE, NEW YORK, NY 10019

CFAE Ad Council

A PUBLIC SERVICE OF THIS PUBLICATION AND THE ADVERTISING COUNCIL

Medical Alert



Do You Know This Vital Sign?

To professionals in medicine and pharmacy, this is the mark of a distinguished member of the healthcare community—the Certified Medical Representative.

This achievement signifies the successful completion of hundreds of hours of advanced study in pharmacology, physiology, microbiology, biochemistry and other medically-related courses.

CMR candidates learn through home study. Twice yearly, rigorous examinations are given at 50 major universities throughout the country. The completion of this comprehensive educational program is an independent, unbiased way of attaining certification. The program is accredited by the American Council on Education, and is recognized industry-wide.

The results—Certified Medical Representatives—have the vital signs of the medical professionals they serve: dedication and determination, knowledge and understanding, competence and consideration.

Write or call for a free catalog and more information today.

The Certified Medical Representatives Institute, Inc.
4316 Brambleton Avenue, S.W., Dept. SFL 8-5
Roanoke, Virginia 24018
703/989-4596

Know Your CMR

For Cardiovascular Consultations, Call a Specialist. MIST.



The University of Alabama Medical Center

The Division of Cardiovascular Disease provides clinical services in all aspects of disease involving the heart and blood vessels. Faculty members within the division present a broad range of special interests and expertise, including:

- **Cardiac Arrhythmias**
- **Valvular and Congenital Heart Disease**
- **Ischemic Heart Disease**
- **Radionuclide Imaging of the Heart**
- **Electrocardiography**
- **Digital Subraction Cardiac Angiography**
- **Coronary Angioplasty**
- **Coronary Artery Thrombolytic Therapy**
- **Cardiac Angiography**
- **Coronary Artery Angiography**
- **Hemodynamics**
- **Holter Monitoring**
- **Cardiac NMR**
- **Echocardiography**
- **Hypertension**

The division performs all the traditional as well as the newest diagnostic and therapeutic procedures.

Inpatient services are provided in fifty beds maintained in the University of Alabama Hospitals, including seven in a specifically maintained and equipped Intensive Evaluation Unit.

This division of Cardiovascular Disease is one of 41 departments and divisions of the University of Alabama Medical Center accessible to you through this service.

By dialing the MIST number you have access to faculty specialists seven days a week, 24 hours a day. Consultations, referrals, and transfers via the Critical Care Transport Service are as close as your phone.

MIST
Medical Information Service via Telephone

UAB University of Alabama Hospitals
University of Alabama at Birmingham

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC

AUGUST 1985, Vol. 72, No. 8

CONTENTS

PROCEEDINGS

585 Proceedings of the 111th Annual Meeting of the Florida Medical Association, held May 1-5

EDITORIALS

R. G. Lacsamana, M.D. 573 Cracks in the image or what patients think of us

H. Frank Farmer Jr., M.D., 575 The demedicalization of America

Henry L. Harrell Jr., M.D. 577 It's time to start

LETTERS & VIEWPOINTS

Richard L. Glatzer, M.D. 579 CPI an unfair indicator of physicians' charges

Jacob Lazarovic, M.D. 579 HMOs provide good care for less money

Paul J. Schmidt, M.D. 581 Heading for the last round down

John W. Morris, M.D. 581 Why the double standards?

COVER

This month's cover features the winner of the Editor's Award in the Ninth Annual FMA Auxiliary Benefit Art Show. The photograph is entitled "Purple Vein" and was taken by Ms. Michele Schiebler. Michele is the daughter of Dr. and Mrs. Gerold L. Schiebler.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1985 by Florida Medical Association, Inc.

DEPARTMENTS

Luis M. Perez, M.D.	**569**	President's Page FMA's public education program
Jacques R. Caldwell, M.D.	**697**	Medical Economics Indigent care: salvage the system or continue its carnage?
	703	Notes and News
William A. Sodeman Jr., M.D.	**704**	Dean's Message Preventive medicine
	704	Encores!
	710	Scam of the Month
	713	Book Reviews
Mrs. Isabella Laude	**717**	FMA Auxiliary The orange jackets
	720	Meetings
	724	Classified Advertising
	730	Index to Advertisers
	730	FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
Frank H. Farmer Jr., M.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Philip Altus, M.D.
Fuad S. Ashkar, M.D.
Thomas D. Bartley, M.D.
Pierre J. Bouis Jr., M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Mrs. Dale R. Charneco
Charles Craig, M.D.
R. Jay Cummings Jr., M.D.
Raul V. deVelasco, M.D.
Pablo Enriquez, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
James T. Howell, M.D.
Harold L. Ishler Jr., M.D.
Nicholas H. Kalvin, M.D.
Karl J. Kramer, M.D.
Jeffrey Lang, M.D.
Michael S. Levine, M.D.
Richard F. Lockey, M.D.
Mr. Dale Matza
Philander D. Morgan, M.D.
George Morris, M.D.
Richard S. Panush, M.D.
R.A. Penalver, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
Arvey I. Rogers, M.D.
William J. Romanos, M.D.
Hubert L. Rosomoff, M.D.
Lees M. Schadel, M.D.
Frederick W. Schert, M.D.
Jack J. Schneider, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Roberto A. Sosa, M.D.
Michael E. Steier, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victoria, M.D.
George Watkins, M.D.
Charles D. Williams, M.D.
Frederic C. Wurtzel, M.D.

Index to Proceedings

A.H. Robins Award 596
AMA Delegates 633
Board of Governors Report A 616
Board of Governors Report B 620
Board of Governors Report C 637
Board of Governors Report D 673
Board of Governors Report E 682
Board of Governors Report F 650
Board of Governors Report G 618
Certificate of Merit 653
Committee on Impaired Physicians 631
Committee on Membership Development 625
Council Reports
- Hospital Medical Staffs 681
- Judicial 626
- Legislation 666
- Medical Economics 678
- Medical Services 619
- Scientific Activities 614
- Specialty Medicine 615

Distinguished Layman's Award 597
Election of Officers 663
Excellence in Medical Journalism 600
FLAMPAC 632
Florida Medical Foundation 630
Florida Physicians Association 633
FMA-A President's Address 603
General Session 607
Good Samaritan Award 598
House of Delegates
- First House 593
- Second House 612
- Third House 660

Installation of the President 665
JFMA Awards 607
Medical Speakers Awards 597
Michael L. Lopez Resolution 600
President's Address 585
Reference Committee I 614
Reference Committee II 619
Reference Committee III 625
Reference Committee IV 666
Reference Committee V 678
Remarks of the Speaker 595
Ruth Balle Recognition 600
Sanford A. Mullen, M.D., Award 602
Scientific Exhibit Awards 607
Speaker's Bureau 626

Resolutions

85-1 Public Relations Program 653
85-2 Alternative Delivery Systems 685
85-3 Ruth Balle Recognition 654
85-4 Workers' Compensation Medical Fee Schedule 685
85-5 Assignment of Insurance Benefits 676
85-6 1986 Relative Value Study 686
85-7 Relocation of FMA Headquarters 654
85-8 Expert Testimony Requirements 676
85-9 Mandatory FMA Membership 676
85-10 Educational Advertising Campaigns 653
85-11 Organ Harvesting 623
85-12 Limitations to Medical Malpractice Liability 676
85-13 Committee on Membership and Discipline 654
85-14 Florida Physicians Association 654
85-15 Specialty Society Awards 655
85-16 Workers' Compensation Approach to Medical Liability 676
85-17 All Terraine Vehicle (ATV) Injuries 623
85-18 Motorcycle Insurance Requirements 676
85-19 SBME Licensure Renewal Procedures 677
85-20 Continuing Medical Education 618
85-21 Non-Payment of 1984 Assessment 655
85-22 Competition in Medicine 686
85-23 Pre-School Physical Examinations 624
85-24 Medical Licensure 677
85-25 HMO Financial Responsibility 677
85-26 Emergency Resolution 624

FMA's public education program



By this fall a public education program by the Florida Medical Association should be organized and functional.

This program will be two-fold, first emphasizing the advantages of a private practice of medicine and of those systems which are organized and directed by physicians, keeping as a priority the quality of medical care and the principle that we treat patients as a whole and not as isolated diseases.

We are being forced by the government and entrepreneurs, whose eyes are only on economics and the bottom line of a balance sheet, to classify patients by a "cookbook" type system through the DRG concept.

The second part of this program will be to improve the image of the physician in general. According to the latest national surveys, physicians are depicted as cold, impersonal, detached individuals who spend health dollars with contempt and without considering the economics of the patient or the nation as a whole.

We know that none of this is true. We know that most of us work hard and long, keeping in mind the well being and good care of our patients and trying to be as efficient as possible in our professional attitude. However, we can not compromise the quality of care that warrants our patients the fastest, complete recovery, which is the most economical and efficient way to return the individual to gainful employment with less disabilities and the maximum enjoyment of life.

We must begin by educating ourselves to transmit these ideas to our patients, a captive audience with which we have a rapport and who are willing to reason on a one-to-one basis and understand these facts.

As part of this program, we must develop speakers' bureaus within each county medical society and inform civic and religious organizations that these bureaus exist and that members are willing to address any group of interested individuals. The idea we are trying to convey to our members is that the work of this program must be personalized from the grassroots upward. Television, radio and newspaper ads will not do the work we really need; they can help in increasing the public's awareness of the health problems that face our state in particular and the nation as a whole. However, they will never replace the warm body of a speaker who is willing to reason with a group of individuals, answer their questions and put to rest their concerns, correct the misconceptions and falacies that for years have been built up by interested parties in a constant, persistent, methodical manner.

We must all work together and become more active in the public arena. It is our common problem, and the solution depends upon each and every one of us.

With organization and enthusiasm, with logic and reason based on our high standards of moral and ethical principles, we can change the perception of our profession.



CLINICAL ENDOCRINOLOGY UPDATE
Thirty-Seventh Annual

POSTGRADUATE ASSEMBLY
of The Endocrine Society
Sheraton Bal Harbour Hotel, Miami Beach, Florida
October 14-18, 1985

A comprehensive survey of the state-of-the-art in clinical endocrinology and its grounding in recent advances in the basic sciences and technology.

- Basic science overviews for the clinician
- Perspectives on the clinical applications of releasing hormones
- Current concepts of pathogenesis, diagnosis and management
- Assessments of recently developed imaging techniques
- Advances in the endocrinology of growth and of aging
- Clinical Vignettes: Difficult and Uncommon Endocrine Disorders
- Grand Rounds: Problem-Solving with Master Clinicians
- The Endocrine Family Picture Album
- Introduction to Computers (for registrants and guests)
- AMA Category I Credit

Tuition: $425.00 ($375.00 for trainees)

For registration and information write to:
Mrs. Nettie C. Karpin, Executive Director
The Endocrine Society
9650 Rockville Pike
Bethesda, Maryland 20814
Phone: (301) 530-9660

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg





Getting ahead in medicine is an uphill climb.



Unless you have a BellSouth Mobility car phone.

Turn drive time into prep time. This year, our car phones are going to be one of the most popular ways for doctors to control high blood pressure—their own.

Because BellSouth Mobility cellular car phones allow doctors to stay in constant touch. To plan ahead. And to have the frustration of the pay-phone routine painlessly removed by allowing you to give your service an immediate buzz when you get beeped on the road.

Advanced service network. Ours is the most advanced phone system on wheels. It's just as easy to use as your office phone. And it's the only one with a state-of-the-art service network behind it. Making sure that your car phone—and your patience—are state-of-the-art. Now, and down the road.

Call BellSouth Mobility toll-free at 1-800-351-3355. And from there, it's all downhill.

BellSouth Mobility

All you need to know about mobile communications.℠

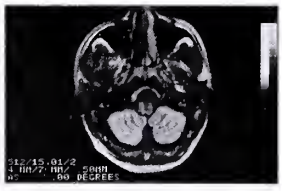
©1985 BellSouth Mobility Inc

Our new Magnetic Resonance Imaging Center will help you care for her, as no one else can.





MRI utilizes a combination of magnetic and radio frequency fields rather than X-rays.



MRI enables you to see past bone for better clarity of image.

Magnetic resonance imaging is one of the most advanced, most accurate diagnostic tools.

It's also one of the safest. It doesn't use X-rays, so there's no concern about radiation side effects. No contrast media is needed, so there's no discomfort and little chance of allergic reaction.

But there's one thing the MRI Center can offer that few others can. The staff of Miami Children's Hospital. People trained and experienced in the special care and consideration you want for your young patients.

Find out more about our MRI Center. Call us today to arrange for a guided tour or a free brochure at (305) 662-1564. Or use the coupon below.

M·R·I
DIAGNOSTIC CENTER
miami children's hospital

I'd like to know more about the Magnetic Resonance Imaging Center at Miami Children's Hospital.

☐ Please call me to arrange a tour.
☐ Please send me a free brochure.

Name

Title

Address

Area Code/Telephone

Best Day/Time to Call

Complete and mail to Miami Children's Hospital, 6125 Southwest 31st Street, Miami, FL 33155. Or call (305) 662-1564.



MRI allows you to identify diseases that were previously recognizable only during a surgical procedure.



Multiple images of the human body are available from sagittal, coronal, and axial perspectives.

Cracks in the image or What patients think of us

Physicians recently have been suffering from an unusual affliction: bruised egos. Polls taken the past few years have shown unmistakably that the public is changing its perception of the medical profession. While most Americans still revere their doctors, a growing number of them are also getting disenchanted. This change in attitude has caused ripples of discontent in the profession, and there is now a swelling tide of urgency that physicians must do something to restore their image. The AMA and the FMA underscored the importance of the problem when both organizations decided that improving the public image of physicians would be one of their top priorities for this year.

Physicians who have been feeling the public pulse through polls conducted for the AMA and other organizations may feel that the picture is not as bad as it looks. Perhaps so. After all, majority of those questioned still expressed satisfaction with their individual physicians and in their professional abilities. But what about the other things that increasing numbers of Americans believe in? They are disturbing, and here they are: we went into medicine mainly for the money and prestige; we don't care about people as much as we used to; and we are not spending as much time as we should on patients. That is a short litany of shortcomings but they strike at the very heart of our profession. We should have reasons to be concerned; if things do not get any better, one can only imagine what the public will be saying about us a year or two from now.

Those of us who have been practicing our profession for years and who have been doing a good job probably should feel less concerned about these perceived problems in our image; we can always comfort ourselves with the thought that only a few physicians are causing these problems and that, with time, as we ferret out the bad elements from our ranks, our public image will start glowing again. But it is not as easy as that. Skirting the problem in this manner is probably the worst thing we can do. Public perceptions, whether true or not, are hard to die, and can cause the medical profession irreparable harm unless they are dispelled or corrected. The prospect of having a poor public image should never escape us: look at all the trades and professions that have never lived down their bad image because of the lasting imprint that it leaves on the public consciousness. The volatile environment in which we now practice, where physicians are in hectic competition for the shrinking health dollar, may make us vulnerable to the kind of things that the public is accusing us of.

Any activity or program that physicians should embark on, either individually or collectively through their medical organizations, should focus on those things that, in the public judgment, are tarnishing our image. This requires examining what patients are telling about us, dispelling them where they are false, acknowledging those that are true and taking steps to correct them, and educating the public about them. We may be surprised that patients are telling the truth about us more than we care to acknowledge.

Is there any truth, for example, to the growing public perception that physicians entered the profession of medicine primarily because of the prestige and the money? The question may sound revolting, mocking as it does the noble roots of the profession, the unmatched record of service of physicians to their fellowmen, and the altruistic ideals of young men and women who are following their profes-

sional forebears. That may be true; unfortunately, begging the question and invoking the past and the traditions of the profession are not enough nowadays. But what about the intellectual challenges, the professional and personal satisfaction, and the ability to practice a profession with so many splendid opportunities unmatched by any other calling? Those are probably more compelling motives than purely material considerations. Sure, sure, we all know about these things; and so does the public. The practice of medicine is all these; 44% of Americans, however, believe otherwise. Can they be right?

They are only partially right. Not all physicians are altruistic or intellectually challenged by medicine; there are those who no doubt became physicians because of the boundless opportunities to pile up money and to bask in the public glow accorded to members of the medical profession. But they are a small minority. Nevertheless, it is these few scoundrels who give the whole profession a bad name.

Side by side with the perception that physicians are motivated mainly by money and fame, the same poll respondents think that physicians are charging excessive fees. Again, this is probably true for a small number of physicians, and it is bolstered by common knowledge in the profession of certain medical procedures and services fetching handsome financial rewards out of proportion to the time and skills involved. The internecine snipings of one segment of physicians against another about the disparity in fees between cognitive and procedural services make us feel uncomfortable about fees. But there is one bright note. Where only 32% of those questioned in 1983 felt that their physicians' fees were reasonable, 71% in 1985 feel that physicians' fees are reasonable. It is obvious that the freeze on Medicare fees by the government had a lot to do with this dramatic shift in public attitude.

Fifty-four percent of patients also believe that physicians are not as compassionate as they once were. This is nothing new; what is new is the increasing number of people who believe so. The usual reason given by physicians for this public belief is that the traditional family physician who held hands with Grandma and comforted the family in a night-long vigil is gone; in his place is the superspecialist whose focus is narrow and whose armamentarium consists of the use of high technology instead of the warm and personal relationship that the caring and compassionate physician of old has developed into an art. There is nothing wrong with narrow and specialized care; the advent of advances in all fields of medicine has made this necessary. Modern physicians are fond of saying that being able to diagnose and treat a patient's problem is the greatest act of compassion. That is true to a certain extent, but many of us are also familiar with stories of countless patients who have been brutalized by the coldness, the impersonality, and the brazen lack of feelings by many physicians. A fusion of caring and high technology should not be incompatible.

A still bigger number, 61%, believe that physicians do not spend as much time on patients as they used to. Part of this is related to the thinning ranks of primary care physicians, who usually spend the most time with patients, and to the ever increasing number of specialists whose busy schedules restrict them from taking the time to get intimately acquainted with their patients. The story of patients who wait for two to three hours to see the doctor and then get dismissed after a five-minute visit has become a familiar refrain to us. In addition, the highly competitive environment may be forcing physicians to see as many patients as they can in their offices, leaving them little time to sit down and explain things to patients. The new types of health care delivery systems, with their impersonal character, their big patient loads, and their emphasis on economics, also do not foster an atmosphere where physicians are given adequate opportunities to spend time with their patients. There is probably little we can do about some of these things; at the same time, the fact that the public is complaining about them should sensitize us to the problem and realize that patients want more than a cursory examination or a hurry-up job.

It should be obvious, from examining these public attitudes, that there are cracks in our image; equally obvious, we must act to stop these cracks from getting bigger. The favorable public image that we have had for years is rooted in tradition and our ideals of service; it is what makes medicine a unique and noble calling. We need to preserve that. We must assure the public that even though medicine is going through a troubled period, its focus will always be on providing humane care for people and preserving the excellence of that care.

What can we do to project the best image for ourselves and for our profession? Plenty, both individually as practitioners and collectively as members of our medical organizations.

Physicians as individual practitioners have a far better image than as collective members of organized medicine. That should afford them a better vantage point to discuss with patients what their concerns are. If we have been remiss in the past, we now must listen and take more time with them, make them feel that we care for them as people, and charge only what is reasonable. Whether we are generalists or specialists, we must employ technology not to abridge our relationship, but to complement the human warmth that is often frozen by the cold stare of our machines. We also must educate patients about the many changes in medicine, the repercussions of these changes to the future of medical care,

and the necessity to accept reforms and to reject those things that will destroy our current medical system. Having patients on our side will be helpful in our forthcoming battles in the political arena. There are other small things that patients appreciate from their doctors: a smile, a pat on the back, a helping hand, words of encouragement, a cheerful attitude from the office staff, and an offer to fill out the insurance forms. There is little glamour in doing these things, only the satisfaction of helping people, which is the hallmark of our profession.

It is in the collective efforts of organized medicine, from the county medical societies to the AMA, that physicians should be doing a better job at boosting their public image. Our leaders of medicine are cognizant of this. AMA President Harrison L. Rogers Jr., M.D., in his inaugural address, targeted the improvement of physicians' image as one of the four main issues facing the medical profession today. Closer to home, the FMA Board of Governors at its meeting on June 28 approved as one its goals and priorities for 1985-1986 the development of a public relations program designed to build and maintain a positive image of physicians. The program envisions, among other things, the formation of PR committees at the county medical society levels to supplement the FMA program, strengthening the FMA Speakers' Bureau and encouraging the formation of such bureaus within county medical societies, development of programs to help physicians and their office staffs in improving communications and relationships with patients, publication of a newsletter targeted to public officials, and greater involvement with the media in the dissemination of news and expression of the profession's views on items affecting medicine.

The success of any campaign to polish our image both on the grassroots and the national level will require the full participation of physicians. The usual apathy of the past must be replaced by vigorous involvement. There are smug physicians among us who could care less and who feel that polls do not reflect the true situation. This is the kind of thinking that will set back our efforts to advance our cause. Our sagging public image is real and requires concerted action. For those of us who care about our profession, who feel obliged to preserve the best of our heritage, and who feel sensitive to the needs of the public, we must do our share to project ourselves in the best light possible. Our patients are telling us something. If we don't listen to them, nobody else will listen to us.

R. G. Lacsamana, M.D.
Editor

The demedicalization of America

After thirty years of increasing delivery of medical care to the public, the federal government has done an about face. We are now in the midst of an effort to "demedicalize" America. This is a very interesting phenomenon and represents an attempt to redirect the health care policy which has existed in the United States since World War II. It is an effort to return the concept of the delivery of medical care to the days of the 1920's and 1930's. It was during these years that America was in a demedicalized state. This was through no planned action or concerted effort, but was the result of the evolution of medical care to that point in time. Prior to World War II, there were only a few significant advances from a scientific standpoint. Most of the great achievements in the decades prior had been through public health measures and not through technological advances. The control of malaria, hookworm, scurvy, and other diseases was not through medicine or technology, but by careful observations and changes in diet, environment, or personal habits. There had been advances in trauma and surgery, largely as a result of the opportunity afforded by the Civil War and World War I. However, there were few diagnostic tests widely used other than the x-ray in the 1930's. There was no expensive technology and hospitals were still in their infancy. Many small or medium-sized cities did not even have a hospital then.

Americans did not expect much from the medical profession. They were content with physicians being the comforters of the sick, not especially the healers of the sick. In most illnesses, physicians were powerless to alter the outcome. The active role of doctors was largely confined to good nursing care and comforting the patient and family. Diseases ran their courses and neither physicians nor the armamentarium at their disposal usually altered events. As such, America was demedicalized by virtue of its own medical history. We had never been "medicalized." While physicians and medicine were respected, often the medical care of an individual was left to him and his family as they knew that the medical system had little to offer. The doctor was called on only as a last resort and then largely to confirm what was already suspected.

The federal government, the public, and the medical profession lived in this state of affairs until the outbreak of World War II. If there is a dividing line between the events which went before and those which followed, 1941 would be that line. With

the outbreak of World War II, America would embark on three decades of trying to prove that more medical care and more medicine was better for America. It was a period of time when America was truly medicalized. In the process, our mores, concepts of health care and the economic aspects of the health system would undergo tremendous change and America would never be the same.

The changes were subtle at first. The military recognized that more training or specialization was desirable and those with special training entered the armed forces as a captain and the generalist entered as a lieutenant. By this difference in rank, the federal government showed that more was better and would be rewarded. Physicians recognized that specialty training appeared to be what the federal government wished. For this reason, the advent of specialty training would evolve out of the attitudes of military medicine during the war. Of course, there were other factors leading to specialization, but the war was the culmination and the pivotal point from which specialization would flow. Specialization was further enhanced by the fact that the federal government would start pouring millions of dollars into training programs and research designed to help turn out the specialist.

The war gave the opportunity for increased antibiotic usage with the production of pencillin on a large scale. Suddenly, diseases that were incurable a few years before were now miraculously cleared up with a few injections of penicillin. There were other technological advances brought on by the war, such as blood banking, new surgical techniques learned on the battlefield, and the administration of a large medical care system with its thousands of hospitalized patients. The war provided the initiative and the opportunity for the expansion of the role of the federal government. The nation was impressed by the advances and by the end of World War II was psychologically ready for a rapid move to the medicalization of this country. The government moved rapidly to control and direct the movement. In 1946, the Hospital Survey and Construction Act, better known as the Hill-Burton Act, was passed. This provided funds to individual states for the planning and construction of hospitals. Since that time, several amendments have been passed and in 1969, 267 million dollars were spent. The Hill-Burton Act was the reason for thousands of hospitals to be built across the country. There was little planning of need or bed occupancy rates. Every community wanted its own hospital and they sprang up like mushrooms across America's landscape. Along with the hospitals came the ancillary services usually asociated with hospitals, such as radiology services, lab services and surgical suites. Americans wanted to be hospitalized. After all, this was thought to represent the zenith of medical care. The insurance companies also recognized a desire for more medical care and persuaded employers to provide first dollar coverage. The federal government passed Medicare in 1965, which was to provide medical care for that segment of the population over 65.

The public was inundated about regular medical check-ups, yearly chest x-rays, electrocardiograms and other assorted tests. Some employers even contracted with well known medical centers for their executives to have complete physical examinations on a yearly basis with upper gastrointestinal tests, barium enemas, gallbladder exams, pulmonary function and treadmill testing. All of these for largely asymptomatic patients with the only indication being a yearly exam. Medicare had few limits and paid on the basis of how long a patient stayed in the hospital and how many tests he had. People flooded to the hospitals for tests and physical exams as most health policies covered only inpatient care. This was an attempt, the insurance companies would later say, to save money by doing away with unnecessary tests which was felt to be done only as an outpatient. Patients and physicians, unfortunately, rapidly outwitted the health companies with hospital admissions solely for test purposes. This went on for three decades and served two purposes. It showed that the health care planners, insurance companies and Medicare were uneducable as to what was happening. If they did see what was happening, it was well disguised. There was very little planning either for the present or for the future. America seemed to be caught up in a ride to infinity on the health care train. The second purpose was to implant in the mind of the public that revenues for health care were limitless and indeed were to be used as quickly as possible. The government furthered this blind march as it inaugurated the renal dialysis program against criticism that future spending would far outstrip the money available. The amount of money spent for health care was on an upward spiral with no end in sight. In 1950, 4.6% of the gross national product was spent for health care. By 1975, this had risen to 8.3% and represented $547 for every person in the United States.

As the desire for more medical care continued, the federal government poured millions of dollars into medical schools to provide more doctors, to do research for new products and technological advances. Out of this would come, almost daily, new products with heart catheterization, CAT scans, new class of antibiotics, coronary artery bypass, liver, kidney and heart transplantation and other innovations.

Suddenly, by the mid 1970's the high cost of medical care was becoming apparent to the consumers, insurance companies and finally the federal government. At this time the demedicalization began. Many of the things which have been im-

printed on the nation's psyche were now pronounced as being wrong. The yearly physical exam, chest x-ray, electrocardiogram all came under question as being "cost ineffective." Medicare inaugurated DRGs, a system of prospective payment to cut down hospital costs. Insurance companies quit providing first dollar coverage, mandated second opinions and increased deductibles. All of these were designed to cut down the utilization of medical care.

Unfortunately, the same lack of planning which characterized medicalization also is prevalent in the demedicalization process. As we demedicalize, we also include those items which were found to be cost ineffective. Is there any rationalization for the refusal of Medicare to reimburse the flu vaccine when all evidence points to the savings in millions of dollars for avoided cost and disability benefits for some of the patient population? Surely, the evidence has been adequately presented for the savings of money and lives for performing annual mammograms in women over 50. Yet, Medicare does not recognize this as a legitimate reimbursable item. The Pap smear is another test which has saved thousands of lives performed on a regular basis, but is also not reimbursable unless there is a specific diagnosis.

Recently, Medicare has cut reimbursement for home care. This comes on the heels of DRGs. Supposedly, the whole concept of DRGs was to get people treated on an outpatient basis as quickly as possible. The saving grace of DRGs was that there would be many types of treatment which could be provided by nursing care providers. However, the federal government in its infinite wisdom has decided to trim this aspect of Medicare and now people who are discharged early and who need home nursing care will have some of this service stripped from them.

For any thinking person, there is no argument that many of the tests, which we as physicians ordered, and a great deal of the hospitalization that we did, were unnecessary. We cannot escape from this fact, nor can we avoid responsibility for our part in the events that led to demedicalization. However, other entities, most notably the federal government, will have to take some of the responsibility for being involved in a process which seems doomed to repeat many of the same mistakes which was done as we rushed to medicalize America. By not taking into account what went wrong when we medicalized America, we are surely going to repeat the same mistakes and I fear we are going to end up with a product, after the demedicalization has been completed to the satisfaction of the federal government, that is lacking in both adequate medical care and financial savings. It took 30 years to medicalize America and we appear destined to demedicalize in one third of the time. If the same mistakes are made in the process then that means that we will probably have three times as many mistakes and will end up with a product that has three times as many shortcomings as what we had less than five years ago. Yet, the federal government will have achieved its purpose in demedicalizing America and we as physicians and the consuming public will be the recipients of these results.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

It's time to start

As the summer draws to a close there has been time to relax a little this year to enjoy the experience of relief at having at long last obtained a reasonable malpractice reform bill from the state legislature. Before the 1985 session started, there were rumours circulating widely that this would be a "do-nothing" legislature where malpractice was concerned. A state-wide task force was preparing its report. Physicians were unusually charged with political activism after having ridden the emotional roller coaster of excitement over the promised campaign for Amendment 9 followed by discouragement and cynicism when the measure was thrown out by the Supreme Court. The public had finally begun to have an interest in the malpractice crisis and to understand that it had begun to effect their medical care. And despite all that pressure, many of those who were supposed to "know about such things" thought that the legislature would again pronounce the malpractice crisis to be a figment of doctors' imaginations and do nothing.

It came as something of a surprise then when real progress did come. The bill that passed was not perfect. In fact it fell far short on several important issues. But it was a step — a large step — in the right direction. The House finally admitted that there was a problem, and they took significant action to address that problem.

As Fall approaches it's now time to start to build on last year's victories. Now is the time to start to work on the upcoming legislative session so that more can be done. We sometimes lose sight of the fact that many of our legislators really don't understand our problems. Now, while there is more time to sit and talk with them at length, we have the chance to help them understand. Some of our legis-

lators don't really care about our problems because they don't think most of their constituents care. Now is the time for us to marshal and increase public interest so those legislators may learn to care. Some of our legislators are actively hostile to our aims. Now is a good time to let them understand clearly that we intend to put them in a position of having to defend their hostility if they can.

How do we go about accomplishing all this? Any way that works. Those of us who know a legislator personally should arrange a time to talk with him — not to him but with him. Let him express his doubts or prejudices and let him know yours. If he understands your position better he may support it more effectively. At the very least he will recognize your urgent telegraph on the eve of a big vote as part of a consistent position. It must make legislators feel pretty cynical when large organized groups seem to discover Tallahassee only when some major bill is beyond the point of allowing much chance for allowing much chance for change.

In addition, we must continue to involve our patients and fellow citizens in the campaign. Joint and several liability may seem sensible to trial lawyers but it strikes everybody else as unfair. The average citizen is against it. Most people aren't so sure about the advisability of putting a cap on general damages until they understand that the money has to ultimately come from the pockets of paying patients. This sort of information deserves continued public attention.

As the Summer draws to a close, it is time to put behind us the achievements of the last year and begin to work in earnest toward the further achievements of the next.

Henry L. Harrell Jr., M.D.
Ocala

New Motrin® 800 TABLETS mg

ibuprofen



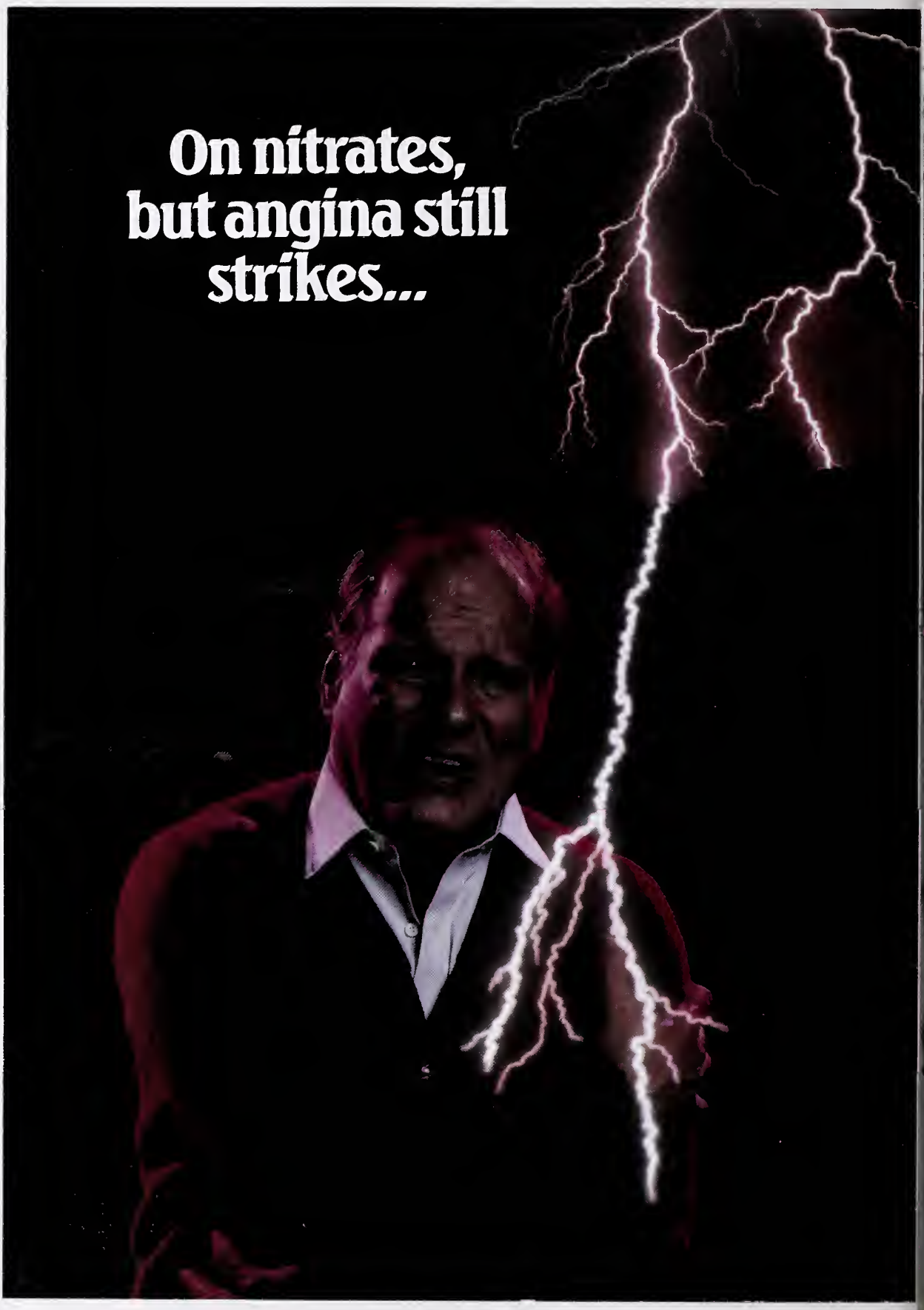
Extra strength
Convenience
Economy

Upjohn

The Upjohn Company
Kalamazoo, Michigan 49001 USA

© 1985 The Upjohn Company

J-5491 June 1985


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT E-SYSTEMS.

"Bonds are a good liquid investment, and if I don't use them, they continue to earn interest."
—L.A. Fulcher



"I put myself and my children through school with Savings Bonds. They're great!"
—Ken Sclater, Jr.

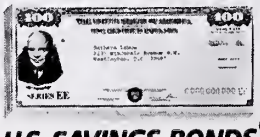


"I save them, but when I want something extra, I know they're there. They're great for emergencies."
—Jose Acosta



U.S. Savings Bonds now offer higher, variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

CPI an unfair indicator of physicians' charges

Dear Editor: I read the article in the June 1985 edition, page 454, entitled "Are Charges Too High" written by Henry L. Harrell Jr., M.D., from the Marion County Medical Society. I find the article totally misleading and an injustice to many of the physicians that he might be accusing. What Dr. Harrell does not take into account are the five-year freeze on medical fees imposed by President Nixon, the present Medicare freeze on physicians' fees, the means by which medical fees are calculated under the Medicare system, and the high costs of medical vendor goods which far outpace the consumer price index.

Of these numerous vendor goods, malpractice is only one and it is quite obvious as to how the escalating cost in malpractice premiums has far outpaced the consumer price index which he quotes. Several years ago, silver skyrocketed in price and x-ray films went up 186% which was far higher than the consumer price index of that year. Silver has fallen in price; however, the cost of x-ray films has not.

I wish I could say that malpractice premiums for high risk groups, especially in Dade and Broward counties, have only increased on the same percentage basis as the consumer price index, but I can't. It is obvious to all of us that malpractice insurance premiums increase, on an annual basis, much more than the consumer price index percentages and, in turn, like any other business, these increased costs are being passed off to the consumer.

In many cases, doctors are still playing catch-up on their fees, thanks to President Nixon, and are also trying to compensate for the financial losses that they are taking from Medicare, Medicaid and Worker's Compensation by increasing their fees to the private patients.

Dr. Harrell is wrong in simplifying the rise in costs of physicians' services by simply comparing it to the consumer price index without any explanation. As in any average, there are highs and lows to reach that mean. Vendor costs to physicians are on the high side of the curve. His simplification of these facts is unfair to those physicians he is indicting.

Richard L. Glatzer, M.D.
Miami

Reply: Dr. Glatzer's points are well taken, and I hope that my article indicated that I agree with him that most physicians are trying to do the best they can in a bad situation. My point was that the situation is made worse for all of us when a few colleagues gouge the system. Apparently others share this concern, since this article evoked more positive comments from my colleagues than any other that I have written in seven years of monthly editorials for our county bulletin.

Henry L. Harrell Jr., M.D.
Associate Editor
Ocala

HMOs provide good care for less money

Dear Editor: It is heartening to read a reasonably scholarly article assessing the virtues or drawbacks of health maintenance organizations ("The Health Maintenance Organization as a Cost Containment Instrument: Logic or Illusion?" Jacques R. Caldwell, M.D., July, 1985, *The Journal of the Florida Medical Association, Inc.*).

Dr. Caldwell concedes that HMOs reduced the costs of health care. This has been documented in virtually every study on the issue. However, Dr. Caldwell's assertion that costs are lower because HMOs attract "the medically well manicured" patients who are healthier and incur less expenses than the populations seeking fee-for-service care is not reflected in the literature. Dr. Caldwell refers to the Rand Corporation's study published in the New England Journal of Medicine which confirms the cost containment attributes of a pre-paid group practice. He neglects to point out that the authors carefully excluded any selection bias in the design of this study. "Because of our experimental design, we can virtually rule out population characteristics as an explanation of the lower hospitalization rate at GHC. We conclude that GHC physicians were simply practicing a different style of medicine from that of fee-for-service physicians. We found no appreciable difference in use between the GHC experimental and control groups, suggesting that there was no risk selection in this case."[1] Common sense and experience in fact suggest that the opposite is true, that high risk patients will select an HMO and subject the organization to the risk of adverse selection. Will a patient with multiple medical problems who anticipates substantial service requirements join an indeminity insurance plan with 80% coverage, or an HMO with 100% coverage where out-of-pocket costs are likely to be nil?

Dr. Caldwell also concedes that there is no evidence to suggest that HMOs practice low-quality care. However, once again, he speculates that this reflects only the healthy populations that are served by HMOs. On the contrary, the Johns Hopkins analysis to which he refers evaluated 27 studies which were strictly controlled for selection biases. Matched groups of both HMO members and fee-for-service members were compared. "Of a total of 27 separate studies, 19 found that the general quality of health care, as indicated by the measures applied, was superior in the HMOs studied to that in general fee-for-service or other settings. In eight of the studies, either the quality of care was found to be similar in both settings, or the total study findings were inconclusive. None of these studies reported HMO care to be inferior overall."[2]

Dr. Caldwell states that "HMOs do not answer the problems of the high cost for the elderly or for the terminally ill or for the chronically ill or for the medically indigent, since HMOs do not serve these people." The Medicare population is clearly taking up HMO membership in increasing numbers. Many states have contracted with HMOs to provide care for their Medicaid populations, and have found the cost-containment effects to be comparable to what has been evident in the non-indigent population. The Health Care Financing Administration is realizing substantial savings by encouraging Medicare members to join HMOs under the new risk contracts. With respect to quality of care, the Johns Hopkins analysis concludes that "of particular significance to the field of public health is the persistent finding that quality of care, as measured by a range in indicators, is better for the poor and those with apparent high need in the facility-based HMO setting compared with that delivered to comparable populations in non-HMO settings."[2]

Those physicians associated with HMOs appreciate Dr. Caldwell's reassurance that HMOs are "not inherently wicked or unethical." However, his emphasis on financial motivations as the sole deciding factor for HMO affiliation excludes many other considerations. Physicians may join HMOs in order to practice medicine free of business and financial concerns, not the least of which is the need to generate services in order to achieve increased revenue. Security, enhanced personal lifestyles because of sharing of coverage, professional satisfaction, ample education benefits, and group interaction and stimulation are other key factors for HMO affiliation.

Finally, Dr. Caldwell's interpretation of the recent Louis Harris "report card" on HMOs, sponsored by the Kaiser Foundation, is highly selective. In fact, the report states that "more than eight in ten executives in companies offering HMOs report positive experiences with pre-paid plans. Over three times as many executives report that HMO membership has decreased costs to their companies as report it has increased costs (30% as compared with 8%). Incidentally, the Louis Harris survey also has the following statement with respect to the experience and satisfaction of HMO members: "HMO members are more satisfied with their health care services, plan coverage, and costs than our comparable non-members. The greatest difference between members and non-members is in satisfaction with the cost of health care services, but members also tend to be more satisfied with access to care. Overall, 48% of HMO members, 34% of eligible non-members, and 36% of the public quote they are "very satisfied" with the health care services they have used recently."[3]

While the HMO is not the panacea for all the ills of the medical delivery system, neither is it an experiment or a fraud perpetrated on the unsuspecting public. HMOs have existed in the U.S. since 1938, and currently carry 15,000,000 subscribers. They clearly provide care of acceptable quality in a cost-effective manner that generates a high degree of acceptance among both members and employers.

References

1. Manning, W.G.; Leibowitz A.; Goldberg, G.A., et al: A Controlled Trail of the Effect of a Prepaid Group Practice on Use of Services. N. Engl. J. M. 310(23):1505-1510, 1984.

2. Cunningham, F. and Willimason, J.: How Does the Quality of Health Care in HMOs Compare to that in Other Settings? Group Health J. 1:4-25, 1980.
3. A Report Card on HMOs, 1980-1984. Louis Harris and Associates, Inc., for the Henry J. Kaiser Family Foundation.

Jacob Lazarovic, M.D., F.A.A.F.P.
Plantation

Heading for the last round down

Dear Editor: The U.S. Public Health Service (PHS) has sent me a notice in regard to some financial dealings that we enjoy, saying that in our future transactions any final dollar amount I receive will be subject to round down. It explains that any uneven amount representing my pennies will be rounded down to the nearest dollar, before I receive my just reward.

The round down policy is new. It is at variance with my annual tryst with the Internal Revenue Service (IRS) which asks me to round off. When I round off any of 49 possibilities between one and forty-nine cents, I can pay the IRS less, i.e. the lower round dollar value. For any of the 50 possibilities between fifty cents and ninety-nine cents, I must pay more, i.e. increase to the amount of the next dollar.

In that IRS battle the odds are then 50 to 49 in favor of the government. Not too bad. However, with the round down, the PHS will always use a lower dollar value. The odds are now 99 to 1 in favor of the government.

Webster's Second Unabridged says that to round off is to reduce indicated accuracy, and it gives also a happy medical meaning for round out, which is to "regain the plumpness of health." It tells us that round up is the gathering of scattered persons or things, such as (U.S. West) cattle. However, Webster is very specific that round down is not what the PHS says it is. It is a nautical term which should interest the PHS since it was founded to care for America's merchant seamen. It means "to haul down on (a tackle) so as to lower the lower block." To a landlubber, that double lower doesn't mean much, but to an accountant in this Republican administration, it must have been an inspiration.

So someone in the PHS has created a new meaning for round down. Surprisingly, it is not too far from Webster's square up, which means to "settle accounts, to pay off." Perhaps the medical profession is the first to square up with the round down. I expect that the disease will spread and that the IRS will apply it to most people, including those who have not yet rounded out, i.e. to patients as well as to doctors. Then despite the ugly use of the two d's in juxtaposition, the round down, or even the round-down or roundown, will mean that everyone must pay up from now to the last round up.

Paul J. Schmidt, M.D.
Tampa

Why the double standards?

Dear Editor: I was absolutely shocked to read that Governor Graham had signed legislation allowing physicians from the Mayo Clinic to practice medicine at their new facility in Jacksonville without the benefit or privilege of a Florida license obtained in the same manner as any other physician now practicing.

Few would doubt the competency and excellence of the physicians of Mayo and the reputation of that Minnesota institution. Clearly, the legislative intent must have been to facilitate Floridians' access to a Mayo branch in Florida. But with the simple stroke of the pen, there is created a double standard of practicing physicians: those licensed by Florida through examination by the State of Florida, FLEX, or National Board of Medical Examiners, and those who practice by mandate of the authority of the Governor's fiat. This edict effectively emasculates the medical licensing board by diminishing its scope of authority and undermining its responsibility in determining the qualifications of practicing physicians, and in providing Florida with qualified medical practitioners and in disciplining those who fail to maintain standards, a vital key to the control of malpractice in our state.

These physicians, however fine, still must answer to the State of Florida and its licensing authority to practice medicine here. The State of Florida simply cannot allow two standards of qualifications for medical practice in our state.

John W. Morris, M.D.
Daytona Beach

The AMA puts current information at your fingertips



The first nationwide medical information network brings a new dimension to the way in which physicians can keep abreast of the latest knowledge in their profession. Through the use of a low-cost computer terminal you can have access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips . . .

DATA BASES:

Drug Information

- Contains up-to-date information on the clinical use of drugs
- More than 1,200 individual drug preparations marketed over some 5,000 trade names
- Can identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions

Excerpta Medica Physicians Information Retrieval and Educational Service

- Index to clinical literature — aids subscribers in locating recent articles and peer reviewed papers that have appeared in more than 300 medical journals worldwide
- Periodicals selected for inclusion in this service cover over 78 specialties and subspecialties
- Helps physicians locate relevant articles quickly and to stay abreast of new developments — saves time

Continuing Medical Education

- Developed by Massachusetts General Hospital in conjunction with the Harvard Medical School
- Allows physicians to earn Category I ACCME credits
- Provides individualized self-paced learning experiences based upon computer simulated patient cases
- Physicians will interact with teaching situation through four predetermined styles: multiple choice, vocabulary, fee text, and tutorial
- Provides confidential means of self-assessment for practicing physicians
- Solutions to problems presented in each teaching scenario can be reviewed and evaluated instantly

Socio-Economic Bibliographic Information

- Guide for locating current articles on the nonclinical aspect of health care
- Includes 4,200 citations from more than 700 health care publications
- Subject areas include economics, education, ethics, international relations, legislation, medical practice, political science, psychology, public health, sociology and statistics
- Convenient ordering of full text reprint of articles directly from the AMA through MED/MAIL

Medical Procedural Coding and Nomenclature

- Provides uniform coding and nomenclature system for reporting medical services and procedures performed by physicians
- Contains 6,000 descriptions of procedures

Disease Information

- Contains descriptions of diseases, disorders and conditions

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION,
PLEASE CONTACT THE
FLORIDA MEDICAL ASSOCIATION, INC.
JACKSONVILLE, FLORIDA
TELEPHONE 904/356-1571



No One Is More Ill Than A Patient Who Tries To Hide His Illness From His Doctor.

You know it's not your everyday patient problem. Alcoholism is far different from most other diseases. Patients try to hide it from you. They resist treatment. They deny they have the disease at all.

Such a complex physical and emotional problem usually requires extensive evaluation. And intervention counseling is frequently needed.

If you are a specialist in addiction treatment, you're equipped to deal with these problems. If not, consider Brookwood Recovery Center as your specialist and partner in the treatment of alcoholism and drug abuse. We're a specialized facility staffed to serve both your patient and patient's family. Our nationally recognized treatment programs have given us one of the best recovery rates in the country. And once recovered, your patients and their families return to being the kind of patients that let you help them once again.

For further information on how a Brookwood Recovery Center can help you effectively treat this problem, call our treatment center in Orlando (305/841-7071) or Tampa (813/884-1904 or, toll-free in Pinellas County, 813/447-4806) anytime, day or night.

BROOKWOOD RECOVERY CENTERS

A health care service of American Medical International

THE CHANGING PRACTICE OF MEDICINE

The changes are all around us. New HMO's. Increasing numbers of medical school graduates. Pyramiding patient insurance headaches. Lack of dedicated personnel. Increasing malpractice suits and premiums.

This is a special invitation for you to Aim High as a member of the Air Force Health Care Team.

One of the advantages you would enjoy with us is time. Time for your patients. Time to keep professionally current. Time to relax. 30 days of vacation with pay each year.

Another advantage is peace of mind—financial security now, and a generous retirement if you qualify.

Leave the administrative hassles to others. Find out about an Air Force practice by calling me in complete confidence.

Major Ron Bailey
(305) 494-2728

One Hundred Eleventh Annual Meeting Florida Medical Association, Inc. Diplomat Hotel, May 1-5, 1985

President's Address
Frank C. Coleman, M.D.

Mr. Speaker, members of the House of Delegates and guests, just a year ago, I stood before you as your newly installed President, and in my brief remarks at that time, I called for unity and participation in a time of great change. I suggested that our obligation as physicians, as it always has been, is to provide quality medical care regardless of the changing times. I indicated that the theme of my administration would be: One Profession — One Association — One Future.

As one profession, no matter what specialty we are, no matter what our mode of practice, we are all physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

We are one association. The state association, in cooperation with all the county medical societies and the specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and philosophy that meet the needs and further the goals of all physicians, regardless of their individual attributes and circumstances.

We all have one future. What happens to one of us happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians, or we all fail. Whatever differences exist, our response to problems of the future — be they legislative, economic, professional or scientific — must be focused toward the needs of all.

Since that day a year ago, the changes of which I spoke have occurred with a rapidity and magnitude that far exceeded what I had believed possible.

An article in the *Wall Street Journal* on March 18 contains a quote which provides at least a partial explanation. This article, entitled "More Firms Are Telling Workers Which Doctors They Should Use," contains the following statement:

> "The U.S. health-care system is in the throes of a revolution," says Jeff Goldsmith, a health-policy consultant to Ernst & Whinney, the accounting firm. "Power so carefully accumulated for almost five decades is shifting from those who provide care to those who pay for it."

Those of you who attended our Leadership Conference in February heard Paul Starr, the author of *The Social Transformation of American Medicine*, describe how this change is occurring.



Frank C. Coleman, M.D., FMA President

I can report to you that my administration as your President has been a very active one. The action began on May 7, 1984, one day after my installation, when representatives of the Commissioner of Insurance, armed with a court order, served notice on our Florida Insurance Reciprocal that the Reciprocal had 30 days in which to indicate that it could meet the reserve requirements of the Florida Insurance Code. The Insurance Department had, in effect, taken over the management of the Reciprocal.

The Florida Medical Association reacted promptly by first identifying the problems of the Reciprocal and, second, looking for solutions to these problems. After many, many meetings that involved the Insurance Commissioner, representatives of the American Medical Association, other insurance carriers, and the FMA, an agreement was worked out with the Physicians Insurance Company of Ohio (PICO) for it to take over the Reciprocal. This occurred on January 3, 1985. The Reciprocal is now operating in a sound and effective manner.

During these months of negotiation, a great deal of misinformation about the troubles of the Reciprocal was circulating. Detailed investigations of the Reciprocal were made by the American Medical Association, the Insurance Commissioner's staff, and PICO. None of these investigations turned up evidence of criminal or fraudulent behavior on the part of those involved in the previous management of the Reciprocal. Reports on these investigations did raise questions about management decisions, including investment policy and rate structure. Because of continuing concerns expressed by the members, last fall the Florida Medical Association retained the national auditing and consulting firm of Ernst & Whinney to make a detailed audit of the Reciprocal. The Ernst & Whinney report reached the same conclusions as those reached in the other investigations. A copy of this Ernst & Whinney report was sent to every member of the Florida Medical Association for review.

I would suggest to you that the time has come to put the old Reciprocal problems behind us and concentrate on the problems of the present and of the future. PIMCO, the company that previously handled the management functions of the Reciprocal, has been dissolved and no longer exists, so there are no vestiges of the past linked to the new rehabilitated Reciprocal.

I would now like to discuss the most serious problem facing physicians in Florida at the present time. The problem is that of the medical malpractice insurance crisis. Those of you who have been practicing for more than a decade remember the previous crisis of 1975 when the Argonaut Company precipitously withdrew from the Florida market, leaving the majority of physicians in our state uncovered for liability insurance. The problem was brought promptly to the attention of the Legislature by the Florida Medical Association. The Legislature responded by enacting several statutes. These included: an enabling act for a physician-owned insurance company, which became the Florida Physicians Insurance Reciprocal; a patient's compensation fund; and a mediation panel system.

That crisis stabilized rather quickly, and for several years premiums were almost level and claims were stable although there was some increase in the size of awards. In 1980, however, the Florida Supreme Court, in response to the third effort of the Florida Academy of Trial Lawyers, declared the mediation panel law to be unconstitutional.

Almost immediately, claims quickly increased in number and the size of awards sharply increased. In 1984, Florida, although seventh in size, ranked third of all the states in the number of awards, and first in the size of awards. The Florida Medical Association reacted to this rapidly developing crisis by going to the Florida Legislature in 1983 with a Legislative Program which would have provided relief. We were successful in the Senate but could get no action in the House of Representatives. The Speaker of the House was a trial lawyer who adamantly refused to let the bill up for consideration on the floor. In 1984, another effort was made with the same result, since the cast of characters was still the same.

In anticipation of this result, by unanimous vote of the House of Delegates, a decision was reached in January 1984 to take the issue to the people in the form of a constitutional amendment to be funded by a mandatory assessment. Constitutional initiatives in Florida must adhere to rather rigid requirements in order to qualify for the ballot, which include obtaining a large number of petitions. In 1984, approximately 300,000 signatures were required. After the petition had been drafted, a campaign to obtain the required signatures was begun. Support of this petition drive by physicians was excellent in some parts of the state and not so good in others. In order to meet the required deadline to get the petition on the ballot, it was necessary to retain a firm specializing in this field. The petition drive was successful in that more than 600,000 signatures was obtained.

After validation of signatures, the amendment was certified for the November 6 ballot. Shortly thereafter, the Florida Academy of Trial Lawyers filed a lawsuit in an effort to get the amendment off the ballot. This lawsuit was first tried in the circuit court in Tallahassee. Judge Ben Willis, who heard the case, promptly ruled in favor of the Florida Medical Association. The trial lawyers then appealed to the Florida Supreme Court.

In spite of the prompt and favorable ruling by Judge Ben Willis, however, the Florida Supreme Court rather precipitously, and in what I believe was

largely a political rather than a legal decision, ruled that our amendment did not meet Constitutional requirements and struck it from the ballot. This decision was based on reasoning that first appeared when Proposition One was stricken from the ballot. This reasoning was vastly different than that which had been followed with respect to previous amendments, such as the gambling amendment of several years ago.

At the time the Constitutional Amendment was approved by the House of Delegates, an active educational program was launched by the Florida Medical Association to provide public understanding of the seriousness of the medical malpractice crisis and of the implications for every citizen of our state. The Florida Academy of Trial Lawyers reacted with a public relations campaign of their own which was about as scurrilous as any that I have ever seen. We had anticipated this attack and had prepared appropriate responses that were to be used during the last two or three weeks of our campaign.

Coming right on the heels of the Reciprocal's troubles, this demise of Amendment 9 increased the concerns of many of our members. That is understandable, for we still have the medical malpractice crisis with us. Amendment 9, however, was a very productive effort for the Florida Medical Association. For the first time, we were able to develop enough understanding on the part of the public that there is a problem, that it is serious, and that it is costing the people of Florida a great deal more for health care than in necessary, and that it is interfering with both quality and access to health care.

The old cliché of the Florida Academy of Trial Lawyers that there really would not be a problem if the doctors would clean up their own act and get rid of the "bad doctors" and, further, that there is no economic problem here because liability insurance premiums represent only 2½% of a doctor's income is no longer blindly accepted. Neither of those statements is true, but as is frequently the case, repetition leads to acceptance on the part of many people.

Last fall, the six business coalitions for health in Florida set up a task force on medical malpractice. These coalitions are composed primarily of businessmen who are concerned about the cost of health programs for their employees and their dependents. This task force was composed of representatives of major businesses and industry. The task force held hearings throughout the state and many witnesses were given the opportunity to present their views on medical malpractice problems. I testified on behalf of the Florida Medical Association.

This business coalition task force has finished its work and has prepared a report which contains some important recommendations. These include: The strengthening of the Board of Medical Examiners' ability to ensure that foreign medical graduates have adequate medical training; mandating professional liablity insurance coverage for all physicians in the minimum amount of $150,000 per claim and $450,000 per year; mandating 12 hours of continuing education during the previous 24 months and an additional 3 hours of continuing education in the area of risk management; expanding the entities required to report disciplinary action against physician staff members to include health maintenance organizations and ambulatory surgical centers; eliminating the doctrine of joint and several liability; mandating the establishment of internal risk management programs in all hospitals; changing the standards of proof in medical malpractice actions from "the greater weight of the evidence" to "clear and convincing evidence"; requiring that medical experts in medical malpractice cases must have been engaged in the practice or teaching of medicine within the 24-month period preceding the alleged act of malpractice; and placing a limit of $500,000 on non-economic damages (excluding punitive damages) in any medical malpractice case.

In addition, the task force is recommending to the Legislature that it study an appropriate limit to be placed upon contingency fees or, in the alternative, that the Legislature adopt an appropriate resolution to the Supreme Court, requesting that the court impose such a limitation. These recommendations have been converted into Legislative language and will be considered by the Legislature.

Late in the 1984 Legislative Session, Senator Dempsey Barron introduced an alternative proposal to deal with the medical malpractice problem. His proposal would remove medical malpractice from the tort system and place it in a new system which would resemble in many respects the no-fault automobile insurance and the workers compensation programs. Because there was inadequate time for the Legislature to consider this proposal, the Legislature appropriated $200,000 to finance a Governor's Task Force on Medical Malpractice and requested the Governor to appoint such a task force.

The Governor did appoint this task force and it met for several months. It had a larger membership than that of the business coalition task force and did include three physicians who served with distinction on the task force. This task force concentrated on alternative approaches in the belief that it would be difficult, if not impossible, to solve the medical malpractice crisis by changes in the tort system. This task force completed its work on April 1 and submitted its recommendations to the Governor.

Senator Dempsey Barron, Chairman of the Medical Malpractice Committee in the Senate, has introduced, along with 13 co-sponsors, his revised bill for an alternative, non-tort system for resolution of medical malpractice claims, Senate Bill 1030.

The basic element of the Legislation is to preserve the threshold issue (breach of standard of care), but it is settled by a judge rather than a jury. It proposes that the case be approached as one in contract rather than in tort. But once the obligation to pay damages has been established, this proposal is much more predictable and forthright than the current system.

First, the bill provides for reimbursement for all necessary and customary medical expenses. It also provides for rehabilitation benefits. All of this is designed to heal the person who is injured and to minimize the effects of the medical incident. If the medical incident causes disability that lasts more than seven days, there are specified temporary benefits and specified permanent benefits that are objective and that can be calculated upfront because they are based on the earning history of the injured person. They relate directly to the economic loss resulting from the medical incident. They are designed to replace everything that was lost.

In addition, there are impairment benefits that can be as high as $100,000. These benefits are based upon a determination of the degree of disability the permanent injury causes to the plaintiff. Finally, if death results, there are specific, identifiable death benefits for those who were dependent upon the deceased. There is no provision in the bill for general or non-economic damages.

A person who is the victim of a medical incident would be much better off under the proposal than under the present tort system. If the right to damages was established, he would not have to roll the dice to see whether he would be undercompensated or overly compensated. He would not have to share his award with his attorney (attorney's fees are in addition to the award) and the benefits would be paid forthwith. Moreover, the benefits would be designed to fairly compensate the injured person for the adverse effects of the incident for so long as those adverse effects persist.

It is anticipated that SB 1030 will be agendaed shortly for consideration by the Senate Select Committee on Tort Reform. FMA has been working with Senator Barron to refine the bill and address the technical problems. It is anticipated that this bill along with a bill introduced by Senator Mattox Hair (D-Jacksonville) will be among the key pieces of Legislation dealing with malpractice moving through the Senate.

On April 4, the Chairman of the Special Subcommittee of the House of Representatives on Medical Malpractice, Representative Art Simon, called a press conference to announce the Committee's recommendations for solving the problems related to the malpractice crisis. These recommendations are far-reaching. As Chairman Simon said at the press conference: "The proposed committee bill seeks to accomplish three important objectives: first, prevention of incidents of medical negligence; second, prompt resolution of legitimate claims; and third, affordable liability insurance for all health care providers."

This committee bill, PCB 85-2, known as the Comprehensive Medical Malpractice Reform Act of 1985, is a very complex bill containing 43 recommendations.

Some of these original recommendations are favorable to our position on tort reform, but others are unacceptable.

The positive points include:

1. There are numerous sections that provide additional authority for the Board of Medical Examiners. It is felt this authority is needed to better police the so-called "bad doctor."

2. There is a provision that will provide for agreements to arbitrate under certain HMO and PPO health care contracts. This is a step in the direction of allowing private parties to establish the boundaries under which they will resolve disputes arising over health care delivery.

3. There is a provision in the bill that will allow insurers to offer to groups of physicians medical malpractice insurance on a group written basis. This has heretofore been prohibited under Florida law.

4. The bill addresses the definition of medical negligence and amends the current law to take into consideration the "prevailing standard" of care that is being provided in the community by different health care delivery mechanisms.

5. The bill establishes a sliding scale of contingent fees in medical malpractice cases which will assure that injured parties who receive compensation will in fact be able to obtain a greater portion of the award than they are now able to under the existing contingency fee scheme employed by most attorneys.

6. The bill provides a requirement that attorneys investigate the circumstances and certify that a good faith belief exists prior to filing a medical malpractice action.

7. The bill creates a certification provision for the certification of foreign medical educational institutions.

We have offered constructive amendments on those recommendations that are of concern to us and will continue to press for their adoption. These include:

1. Reducing the threshold for structured settlements to $500,000.

2. Providing an opportunity for a defendant, within a 90-day period following notice of a claim, to offer to pay the claimant's net economic loss, consisting of medical expenses and lost wages, and to pay the claimant's attorney a reasonable fee.

The claimant would be obligated to accept this offer if made within the 90-day period. Penalties would be included to encourage a defendant to make such an offer if one was warranted.

3. Substituting stronger language for elimination of joint and several liability such as included in the Bell Bill, H.B. 622.

4. Amending the requirement for mandatory continuing education by the State Board of Medical Examiners to recognize enrollment in similar programs, such as that of the Florida Medical Association or the American Medical Association.

5. Striking from the bill several of the recommendations, including the liability of health care facilities for the negligent acts of their medical staffs; a special risk category with a premium cap on rates paid by physicians, funded by a 10% assessment against premiums paid by physicians; that section dealing with unnecessary diagnostic testing; and the mandated million dollars coverage per claim with a $3 million aggregate.

Some provisions of the Simon Bill are being violently opposed by the Florida Academy of Trial Lawyers. At the first hearing on the Bill, the trial lawyers were successful in getting the Simon Subcommitte to strike from the Bill the sections dealing with contingency fees and prevailing standards of care.

Some of our recommendations were adopted, including reducing the threshold for structured settlements to $500,000.

We are prepared for very aggressive efforts to restore the stricken sections on contingency fees and standards of care and to gain acceptance of our recommendations when the report of the Simon Subcommittee is considered by the full Committee on Health Care and Insurance and later on the floor of the House when it takes up this Bill.

All the resources of the FMA will be involved in this effort. The outcome cannot be predicted at the time this report is being prepared for you. You will be kept informed, however, of the progress of this Bill, as well as that of the Barron Bill in the Senate.

Whether the Legislature is going to come up with an adequate solution this year or not remains to be seen as the Legislature will be in session for another four weeks. Our position is much stronger than it has been in previous years. We have more understanding on the part of the public; we have more allies in this effort. We have been able to point out that if this problem is not solved quickly, the impact upon costs of health care, access to health care and quality of health care will be severe.

To facilitate public understanding, I have met with many groups, including representatives of the American Association of Retired Persons, associated industries, insurance agents of Florida, leadership of both the House and the Senate, the Governor on more than one occasion, the Insurance Commissioner, and representatives of several other professional groups. In addition, I have met with the editorial boards of the urban newspapers in Florida for a detailed discussion of the problem.

Several months ago the Florida Medical Association entered into an agreement with Dr. Henry Manne, Director of the Law and Economic Center at Emory University, Project Director for carrying out an extensive research project on medical malpractice. We have just received Dr. Manne's report. This is a voluminous report which he has called a medical malpractice guidebook. This guidebook covers every major topic in the area of malpractice.

Various sections of the guidebook were authored by nationally known experts in the field of law and economics as they relate to medical malpractice.

We believe that meaningful reform in the medical malpractice area is impossible without an accurate assessment of where we are presently. Accordingly the guidebook addresses the following aspects of the medical malpractice issue:

1. Statutory efforts and their economic effects, both in Florida and other states.

2. The present state of Florida malpractice law, both statutory and case law.

3. Economic consequences of Florida law with respect to damages for pain and suffering.

4. The law and economics of Florida Insurance Regulation.

5. The various remedial approaches that have been proposed and can be considered in the future.

We also believe that this guidebook will be helpful to everyone concerned about the malpractice dilemma and how to address the correct issues. Furthermore, we have been concerned that we ought not have anymore false starts made in this field or the adoption of proposals that would really not serve the interest of the citizens of Florida. We believe that the guidebook represents the most comprehensive collection of current knowledge there is today. We are hopeful that this work will lend itself to an informed and dispassionate debate on the topic so that ultimately Florida may achieve the best possible means for dealing with the malpractice crisis.

I would suggest to you as members of the House of Delegates that if our efforts, aggressive as they are, are unsuccessful in 1985, we must seriously consider going back to the people again in 1986 with another Constitutional Amendment. We will be much better prepared than we were in 1984 in that we have a great deal more information about the problem and its impact, more understanding of those elements that will result in improvement, and a clear indication that the Legislature is either unwilling or incapable of dealing with the problem.

Dr. Martin Halley, a cardiovascular surgeon in Topeka, Kansas, recently pointed out the complexity of the medical malpractice problem in an article published in *The Journal of the Kansas Medical Society*. I quote:

> It is not a problem of substandard health care practices that can be solved entirely through risk management or disciplinary action against physicians; it is not primarily a controversy between physicians and trial lawyers or between health care providers generally and the legal profession, although this has been suggested over and over by the media; it is not primarily a problem of the insurance industry manifested by rising premiums; nor is it a problem of the makeup of the State Legislature or the State Regulatory Agencies.
>
> It is a problem of either personal injury, or possibilities of personal injury, to patients in this high technology modern health care system in which we live. An astronomical number of decisions and individual judgments for either delivery or non-delivery of care must be made on every patient. Not every patient has a result that is optimal or is what was hoped for by the patient.
>
> The problem is ultimately one of society. There is a very close analogy between what we are now seeing in medical malpractice and the industrial injuries that began to occur as part of the Industrial Revolution. We live in a litigious society where the phenomenon of increasing malpractice claims and awards is occurring while health care delivery has attained heights of success previously unimaginable and where great scientific and technological advances continue. This phenomenon is not limited to health care, but is only one segment of personal injury litigation that is prevalent in the United States today, such as that involving automobile liability, product liability, air and rail liability, homeowner liability and professional liability generally.

We are also living in a society where we have an increasing number of highly skilled and increasingly specialized attorneys who work within the framework of a distorted contingency fee system. There is increased emphasis in law school curricula on medical malpractice, and there is an unquenched thirst of the news media for publicity on all kinds of medical affairs. The influence of greed, both on the part of the trial lawyers and on the part of the public because of the increasing large awards, judgments and settlements leads to more and more lawsuits.

Our entire Legislative program for 1985 is described clearly in the report and the supplemental report of the Council on Legislation. I direct your attention to these reports.

Although preoccupied a good part of the year with the medical malpractice problem, we have been active in other endeavors.

Our efforts to obtain the PRO contract were unsuccessful as you know, just as was the case with most state medical societies. This was due to the differences in the goals of the government and those of physicians. The government placed emphasis on cost saving whereas physicians were concerned about the quality of health care. The objectives in our proposal were therefore not acceptable to the government. Many complaints about the PRO program have occurred, both in Florida and elsewhere. Recognizing deficiencies in the program, the health care financing administration is now in the process of establishing a super PRO to evaluate the 52 PRO programs that are in operation to determine what changes should be made.

The FMA filed an appeal following the awarding of the contract for the PRO and vigorously pursued this appeal. We also submitted a resolution to the AMA in December 1984, expressing our concern about PRO and asking the AMA to take whatever steps are available to make the program more acceptable. Our appeal was recently rejected.

Early in my administration, I appointed several new committees. One of these was a committee on

programs and priorities. Under the Bylaws of the FMA, the Executive Committee of the Board of Governors is charged with the responsibility of long-range planning. Because of the multiple problems with which the Executive Committee has been dealing in recent years, however, long-range planning has not received appropriate attention. This Programs and Priorities Committee was asked to review all activities of the FMA and to make recommendations to the Executive Committee for changes in our programs, including long-range planning.

You will be considering over the next four days a number of recommendations which came from this Programs and Priorities Committee and were approved by the Board of Governors for submission to you. These include:

1. Changing the Annual Meeting time of the Association from May to September so as to strengthen the ability of the Association to deal with our many legislative problems on a more timely basis.

2. Restructuring the Board of Governors so as to give the House of Delegates the authority to elect the four District members of the Board rather than having them appointed by the President.

3. Detailed financial reporting to the House on the finances of the Association.

4. Providing specialty society representation in the House of Delegates.

5. Better coordination with specialty societies, including staffing and Legislative activities.

6. Shortening the time of the Annual Meeting.

All of these recommendations are important in view of the problems that we face. I strongly support all of them and urge you to give them careful consideration.

Anticipated changes in physician reimbursement for Medicare patients and private patients, the development of HMOs and PPOs, the surplus of physicians, the heavy emphasis on cost containment with modest attention to quality of care, will cause many interspecialty and turf problems. Satisfactory solutions to these problems can only be found if all specialties in the profession have the opportunity to present their concerns and, by compromise and efforts at consensus, reach the unity that is so essential for our survival.

Another new committee appointed last year was that on health manpower. We are having increasing problems with allied health groups that want to enter, and in some instances pre-empt, segments of the practice of medicine. We must have a data base on the activities of these groups; we must have individuals to serve as witnesses before Legislative committees and as advisors to spokesmen for the Association. The list of allied health groups that are seeking licensure, mandated insurance coverage and hospital medical staff privileges is increasing and must be updated regularly.

A Council on Hospital Medical Staffs was authorized by this House last year. The Council is now fully organized with strong leadership and is hard at work with programs to deal with problems that are peculiar to hospital medical staffs. One of the first assignments given to this Council was that of promoting risk management programs within the medical staff structure in every hospital of this state. Active risk management programs are one way to help with the solution to the medical malpractice problem. I believe that a risk management program for physicians must be an integral part of the medical staff structure, with another risk management program operating under the jurisdiction of the hospital administration. There obviously has to be some cross fertilization of these two committees.

Physicians in Florida are very disturbed by what they perceive to be a changing attitude on the part of the public toward physicians. There is justification for this concern as recent studies have demonstrated that the status of the physician, although remaining high, is not as high as it used to be. A report from the group on public and federation relations of the American Medical Association was published in February of this year. Interviews, which formed the basis of the report, were conducted in November 1984 by the Houston-based firm of V. Lance Tarrance and Associates. This report indicates the following:

> Sixty-one percent of people believe that doctors do not spend enough time with their patients.
>
> Fifty-four percent believe that doctors do not care about people as much as they used to.
>
> Forty-eight percent believe that most men and women who become doctors today do not do so because they want to help other people, but for money and prestige.
>
> Only 28% believe that young men and women become doctors to help people, and only 25% believe that they enter medicine both for prestige and money and for helping people. This clearly indicates that many people believe that physicians are more motivated by money than they are by a desire to help people.

Those of us who have served on a county medical society grievance committee are well aware that the lack of good doctor-patient communication is responsible for many of the complaints against doctors and the changing attitude of the public toward doctors. The second most common cause has to do with fees because the patient thinks the doctor charges too much. Only a few complaints are registered with respect to the quality of care.

In an effort to change this trend, I support a coordinated public relations program which would involve the AMA, the FMA, and county medical societies. This is currently under discussion, but I believe that the best public relations is good communication between doctors and individual patients.

I have spent a lot of time this year in an effort to improve communication between the leadership of the FMA and the membership. Twenty Presidential memoranda have gone to each member of the Association. I have had the privilege of attending many of your county medical society and specialty society meetings. I have met in an open forum with the Presidents and Executives of the county medical societies. The Presidents and Executives of the county medical societies are now invited to attend meetings of the Board of Governors and are being given the opportunity to participate in the meetings.

As I bring this report to a close, I would like to quote from the report made by Dr. James H. Sammons, Executive Vice President of the American Medical Association, to the House of Delegates at its Interim Meeting last December. I quote:

> Nothing would please me more than to tell you that we are soon to enter upon a new era in which we will quickly solve all our problems, achieve all our goals and confound all our enemies. Unfortunately, we are a long way from finding a New Jerusalem, and I am afraid that we shall have to continue doing business where we are — in the real world.
>
> To be effective in the real world, to deal successfully with other institutions, to meet new public demands, to respond to changing societal needs, is not the simple matter some people think it is. When issues arise, they are generally resolved through a parliamentary process, a process characterized more by accommodation and compromise than by clear-cut victories and defeats. To operate successfully in this world requires understanding the art of the possible, generous measures of restraint and sophistication, plus patience and staying power.
>
> In periods of worry and frustration, such as we are experiencing now, it is often tempting to try the pat and simple solutions that are frequently offered, to consider changes that really have little relevance to the difficulties at hand. The usual result of such actions is the throwing out of babies with the bath water. Rather than yield to simplistic suggestions, it has usually been more effective policy, in my experience, to stay focused on our problems, to work for a wider understanding of our viewpoint, to develop allies to aid us in our causes and to seek modification of objectionable statutes or pursue their overturn in the courts.

I am in agreement with Dr. Sammons. There is no quick fix to our problems, but we must work together to achieve well-thought-out and effective solutions.

By giving me the opportunity of serving as your President this past year, you have permitted me to learn much about you and your concerns, and I want to thank you for the opportunity.

Serving as President of this organization, however, has now become for practical purposes a full-time job, and I see little change in the demands and responsibilities of the office for years to come. This is a matter that will require discussion both by you as the House of Delegates and by the Board of Governors.

Thank you again for the honor and privilege of having served as your President.

First House of Delegates

The First House of Delegates convened at 3:30 p.m. on Wednesday, May 1, 1985 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, with James B. Perry, M.D., Speaker of the House, presiding.

The House rose for the invocation which was given by Sanford A. Mullen, M.D., remained standing for the Pledge of Allegiance, and the singing of "The Star Spangled Banner" led by Mrs. Edie Epstein and played by Dr. Guy Selander.

Dr. Perry announced the membership of the Credentials Committee:

Thomas D. Bartley, M.D.
Gerald L. Stoker, M.D.
Richard I. Barr, M.D.
George E. McLain, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Thomas D. Bartley, M.D., Chairman of the Credentials Committee, announced that 176 Delegates were present, representing 33 component societies, which constitutes a quorum.

A motion carried to seat the Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Elayne E. Cassisi, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; (Absent — Charles P. Gibbs, M.D.; D. Orvin Jenkins, M.D.; Michael Fagien, Student Delegate)

BAY — James T. Cook III, M.D. (Absent — B. Philip Cotton, M.D.; Terrence R. Steiner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D., Richard I. Barr, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.; (Absent — Raymond A. Armstrong, M.D.; Onofre P. Carrillo, M.D.; Ovid E. Vitas, M.D.)

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — George J. Crane, M.D.; Arthur L. Eberly, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Donald D. Sheffel, M.D.; Juan S. A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; (Absent — Alexander E. Hlivko, M.D.)

CLAY — (Absent — Hinson L. Stephens, M.D.)

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — (Absent — Nanjunda Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Byron D. Epstein, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Maraccini, M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Charles F. Tate, M.D.; Emilio A. Trujillo, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Carlos L. Abraira, M.D.; Harlan S. Chiron, M.D.; Jorge DeCardenas Jr., M.D., N. Ralph Frankel, M.D.; Antonio F. Frexes, M.D.; Maurice H. Laszlo, M.D.; William I. Roth, M.D.; Oscar Sandoval, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin,M.D.

DUVAL — Gaston J. Acosta-Rua, M.D., Clyde M. Collins, M.D., James H. Corwin II, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Charles T. Montgomery, M.D.; John A. Rush, M.D.; Jack L. Sapolsky, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — Harvey E. Bernhardt, M.D.; William P. Booras, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric R. Geiger, M.D.; Charles J. Kahn, M.D.; Larry J. Sauls, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — Michael R. Redmond, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Griewe, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D. (Absent — Richard A. Bagby, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Thomas E. McKell, M.D.; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate)

INDIAN RIVER — Donald L. Ames, M.D.; Paul A. Graham, M.D.; Kip G. Kelso, M.D.

LAKE — Joseph A. Comfort, M.D.; (Absent — Joseph E. Holland, M.D.; Robert H. Hux, M.D.)

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland; M.D.; Stephen R. Zellner, M.D. (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; (Absent — William A. Boyce, M.D.; Roger A. Meyer, M.D.)

MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfore, M.D.

MARTIN — Fred S. Carter, M.D.; (Absent — Andrew F. Greene, M.D.; George E. McLain, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; (Absent — William W. Thompson, M.D.)

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Robert T. Hoover, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Walter M. Philips Jr., M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Clarence M. Gilbert, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Robert N. Serros, M.D.; John P. Taggart, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerro, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — E. Joan Barice, M.D.; Robert Burger, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Charles E. Metzger, M.D.; Gilbert R. Panzer, M.D.; Ben R. Thebaut Jr., M.D.; James E. Vance, M.D.)

PANHANDLE — (Absent — James T. Cook Jr., M.D.; Herbert E. Brooks, M.D.)

PASCO — Carl W. Graves, M.D.; Vincent Cotroneo, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; (Absent — Morris LeVine, M.D.; Howard L. Reese, M.D.; William Scmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — (Absent — Edward D. Risch, M.D.)

ST. LUCIE-OKEECHOBEE — Jack W. Barrett, M.D.; Khalil A. Cassimally, M.D.; Manuel G. Garcia, M.D.

SANTA ROSA — David B. Young, M.D.

SARASOTA — Richard J. Beebe, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith Jr., M.D.; (Absent — David L. Thomas, M.D.)

SEMINOLE — Maria P. Perez, M.D.; (Absent — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Harry F. Farmer, M.D.; Martin S. Feigenbaum, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. **The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance,** and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Your attention is called to the format of the Annual Meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee.** Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

James B. Perry, M.D., Speaker
House of Delegates

Guy T. Selander, M.D., Vice Speaker
House of Delegates

A motion carried to adopt the Minutes of the 1984 House of Delegates as published in the August, 1984 issue of *The Journal of the Florida Medical Association, Inc.*

The Speaker introduced the officers of the Association: Guy T. Selander, M.D., Vice Speaker; Frank C. Coleman, M.D., President; Luis M. Perez, M.D., President-Elect; J. Lee Dockery, M.D., Immediate Past President; James G. White, M.D., Vice President; Henry M. Yonge, M.D., Secretary; Yank D. Coble Jr., M.D., Treasurer; Donald C. Jones, Executive Director.

Dr. Perry introduced distinguished guest Dr. Rufus K. Broadaway, AMA Trustee, Dr. Selander introduced Dr. Edward R. Annis, AMA Past President, and Dr. Coleman introduced Dr. Robert K. Casey, Gainesville, who delivered the certificate that qualified the more than 600,000 signatures to have Amendment 9 placed on the ballot by running from Gainesville to Tallahassee.

Remarks — Speaker of the House

A few years ago we all realized changes were occuring. These were beyond the control of physicians as individuals or associations representing their interests. Never in our wildest machinations did we believe the type of antagonistic, vituperative, hostile, aggressive action that we have seen exhibited by the Congress and State Legislatures, with echos of the media, could ever begin to occur.

Since our last formal get-together just one year ago, we have seen the Reciprocal go into receivership followed by a late end run by the Florida Supreme Court on Proposition 1 and then subsequent to that, Proposition 9, as well as the problems with our own professional liability, which threaten to destroy medicine as we know it today, the DRGs, and the PRO problem compounded the fracus. More recently we have seen the one year fee freeze and mandatory assignments becoming a Russian-type permafrost. Perhaps we are myopic, which I seriously doubt, in the list of our problems and regulations. No other profession, trying to do a decent job with controls and quality assurances, has ever been subjected to such harassment. We have survived this "uphill battle" and are here once again to try to and bring as much order and balance as possible under these circumstances, and to stabilize our Association and our own membership with the consentire of you our leaders.

In our position I hope that we can all communicate these efforts to the hospital staffs in our own county organizations and every physician in Florida. We need to answer their searching and necessary questions and receive their input in order to better deliberate and represent them here at this Annual Meeting.

As you know from previous years, but to reinterate briefly, our House of Delegates functions under the Rules of Order as published in *Sturgis Code of Parliamentary Procedure*. This will prevail unless otherwise provided for by the Florida Medical Association Charter or Bylaws, or unless waived or modified by a 2/3 vote of the members present of the House of Delegates.

The FMA Bylaws require Delegates to register by filling out cards at each meeting of the House. The Credentials Committee will attest to this and whether or not there is a quorum present. As a result, roll call will not be necessary.

The Reference Committees have been appointed and will meet to hear discussion and render a report compiled in their own executive session. Every member of the Florida Medical Association is invited to the hearings, to testify at them, and to participate in the discussions so that a consensus may be reached and decision, based on the majority of opinion, rendered and then submitted to this House. Authors or supporters of resolutions must be present to discuss their position and explain reasons for their proposal.

If an individual desires to discuss different issues in front of different Reference Committees and there is a time conflict, notification to the Chairman will suffice. He will take this into consideration and as a matter of courtesy, the problem will be handled expeditiously.

Council and Committee Chairmen are to be able to answer, enlighten, and encourage discussion over their area of expertise to members of the Reference Committee, as well as the membership. Each Reference Committee will have a senior staff person, a recording secretary, and an AMA delegate to monitor proceedings and assist in the discussions as necessary.

As in the past few years, to clarify double negatives, it is suggested that if a Reference Committee disapproves of a recommendation or a report, it should recommend a vote of "No" to the House.

Following the Reference Committees, their own executive sessions will be held and their reports completed. Reference Committee reports will be available for consideration by early Friday morning. This will usually be done in conjunction with the Speaker or Vice-Speaker. By early Saturday, the reports should be available to all delegations for consideration and caucus.

In an effort to expedite the meetings of the House, the Reference Committee will be encouraged to have a consent calendar. This portion will consist of items where there is no need for discussion. These statements will be listed as "approved, refer-

red, filed, or disapproved." Any member of the House can extract any portion of any of the consent calendar for general discussion by making a motion to extract it and having a simple majority vote in the House. This will enable that portion of the extracted consent calendar to be opened for extended debate should it be necessary. The reason for the consent calendar is to allow consideration on the floor with meaningful discussion about events which are more important and pertinent to the Association. Obviously, the more mundane, but nevertheless important, issues which do not need discussion can then be passed over by a simple consent agreement of the entire House.

We know that every delegate has the opportunity and privilege of discussion of any issue that a Reference Committee brings before the House for consideration. We would encourage that this be done in Reference Committee meetings. However, it is realized that this is not always possible and discussion on the floor is then necessary.

We want the majority to rule but the minority to have every opportunity to be heard and to influence the House.

In an effort to expedite the meetings, nominations for all elected officers will be held on Saturday afternoon after the end of the third Reference Committee report. Voting will then take place in booths on Sunday morning for the adjournment of the House. Hopefully, this will help to expedite and eliminate any confusion. We are hopeful that this procedure will allow the votes to be tallied more quickly and the House to be notified of the results in a most expeditious fashion.

We hope this refurbished hotel and the facilities will be conducive to a pleasant meeting with an enjoyable few days away from your practices. It is also hoped that the business of the Association will be expeditiously handled free from the turmoil and tarvail of the office and hospital practices through which we all exist.

God bless you and have a pleasant meeting.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee III for consideration.

At this time, Dr. Perry proceeded to introduce FMA President, Frank C. Coleman, M.D.

Introduction of President

Dr. Frank Coleman took office one year ago at the Palace Hotel in Orlando. It is a long way from Jackson, Mississippi to a medical school in New Orleans, from the early days of pathology to a hotseat as President of the Florida Medical Association. In between, there was a lot of work, a lot of heartache and a honing of an individual who did many things at the Iowa state and AMA level.

His efforts, strengths and abilities are numerous and well known to many of you. I do not desire to reiterate these now. I do want to commend him for surviving, which he and all of us here, without reservation, call the most difficult year of existence in the history of the Florida Medical Association. We have seen some excellent men who wheeled the gavel over the last decade and before this, but never have any of them been required to spend 100 percent of every working day of the entire year tackling one significant crisis after another such as has occured this year. The results have been unbelievable.

In the first week of office, the insurance commissioner's restraining order caused the Association to use its entire resources and staff to rescue an ailing insurance company and save the assets of literally hundreds of Florida physicians whose very economic survival was on the line. It is the story of manipulative diplomacy that is unmatched in the history of Florida medicine.

The problem with the constitutional revision and the late end run by the Florida Supreme Court caused tremendous consternation but through all of this we have come out much stronger than if the resulting resolution had passed. We are however, much more in debt and financially ailing.

In an average year the Board of Governors meets four times. This year, including conference calls, there have been 19 meetings. This is uneneviable, and hopefully will be an unmatched record in the history of the Association.

Without further comment we all owe a debt of gratitude and tremendous praise and honor to a great friend and a job well done. It indeed was uphill all the way.

Thank you, Mr. President for your great year.

Dr. Coleman addressed the House (the text of Dr. Coleman's remarks appear on page 585). The remarks of the President were referred to Reference Committee III.

Dr. Coleman was then asked to assume the Chair to present the A.H. Robins Award for Outstanding Community Service by a Physician. Dr. Coleman introduced Mr. Jerry Kerlin, a representative of the A.H. Robins Company, and announced that Dr. H. Stewart Siddall of Tampa, Florida was the recipient of the award. Dr. Coleman requested that Dr. Glenn Hooper and Dr. Robert Isbell of Hillsborough County escort Dr. Siddall to the podium to receive the award.

A.H. Robins Company Award For Outstanding Community Service By a Physician

H. Stewart Siddall, M.D., a practicing General Surgeon in Tampa, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of several medical professionals, as the recipient of the 1985 A. H. Robins Company Award for Outstanding Community Service by a Physician.

A native of Ravenna, Ohio, Dr. Siddall received his medical degree from St. Louis University School of Medicine. He did his internship at DePaul Hospital in St. Louis. He completed residencies at St. Joseph's Hospital, Alton, Illinois; Northwestern University School of Medicine, Wesley Memorial Hospital, Chicago; and completed a five-year surgery residency, including Chief Residency, at University of Cincinnati School of Medicine, Cincinnati General Hospital. He moved to Tampa in 1970 and established his general surgery practice.

Dr. Siddall has served as an instructor of Pathology at Northwest University, instructor of surgery, University of Cincinnati, instructor of surgery at St. Charles Hospital, a Clinical Associate Professor of Surgery at the University of South Florida College of Medicine and as an instructor of the Advanced Trauma Life Support Program.

As a United States Army Captain, Dr. Siddall served in Neurosurgery Service at the U.S. Army Hospital, Fort Campbell, Kentucky.

He is a member of American Medical Association, Florida Medical Association, Fellow, Southeastern Surgical Association, Hillsborough County Medical Association, Ohio State Surgical Society, Board of Directors of the Greater Tampa Chapter of the American Red Cross, and Phi Chi Medical Fraternity.

Presently, Dr. Siddall is the Chairman of the Disaster Planning Committee of the Hillsborough County Medical Association, Medical Consultant for the Greater Tampa Chapter of the



Dr. Frank C. Coleman, FMA President, presents the A.H. Robins Company Award to Dr. H. Stewart Siddall, of Tampa.

American Red Cross, Medical Director of the Mass Casualty Planning of Hillsborough County, a member of the Emergency Medical and Disaster Task Force of the Greater Tampa Chamber of Commerce Health Care Council, a member of the Disaster Committee at St. Joseph's Hospital and a member of the Hillsborough County Disaster Executive Committee.

As Chairman of the Hillsborough County Medical Association's Disaster Planning Committee, Dr. Siddall was instrumental in the Hillsborough County Board of County Commissioners establishing the office of Medical Director of Mass Casualty Planning in 1980. He has also successfully stimulated the development of reliable radio communications for mass casualty planning.

Additionally, Dr. Siddall assisted in the development of a Disaster Preparedness / Mass Evacuation plan for Tampa Stadium.



Mrs. Gloria Cook of Daytona Beach receiving the 1985 Distinguished Layman Award from FMA President, Frank C. Coleman, M.D.

Dr. Coleman proceeded to announce that Mrs. Gloria Cook of Daytona Beach was the recipient of the 1985 Distinguished Layman Award. Mrs. Cook was escorted to the podium by Dr. Alvin E. Smith of Ormond Beach and Dr. Richard Snodgrass of Daytona Beach.

Distinguished Layman Award
Mrs. Gloria Cook

Whereas, Gloria Cook of Daytona Beach, Florida, has been a tireless and generous supporter of Florida philanthropic and humanitarian causes since the early 1960's; and

Whereas, Her instrumental part in the Daytona Beach Junior Services League's establishment of the Orthopedic Clinic for the treatment of handicapped citizens and her service to this clinic in the capacity of a patient transporter and as a member of its Board of Directors has been of great magnitude; and Whereas, This distinguished individual in 1961, became President of the Easter Seal Society of Volusia County; and

Whereas, In 1962 she was appointed to the Board of Directors of the Florida Easter Seal Society where she served as Secretary, Vice President and President; and

Whereas, This kind woman was elected delegate to the House of Delegates of the National Easter Seal Society where she served this body as the first woman Vice Chairman and as Parlimentarian; and

Whereas, She served two terms as a member of the National Easter Seal Society Board of Directors where she served as third and second Vice President; and

Whereas, In 1980 she was elected to the Presidency of the National Easter Seal Society, becoming the first Floridian and the second woman to secure this post; and

Whereas, In 1967 she was appointed to the President's Commission on the employment of handicapped; and

Whereas, in 1969 she was the National Society's representative to the White House Conference on Food, Nutrition and Health; and

Whereas, This benevolent individual has served as an Auxiliary volunteer and as a member and Treasurer of the Board of Directors of Ormond Memorial Hospital; and

Whereas, This gracious lady has served as President of the Junior Service League, as a Red Cross Volunteer, as a member of the Board of Councillors of Bethune Cookman College, as Director of Public Relations for Seabreeze United Church and as an active member of the Florida Alumni Association of Volusia County; and

Whereas, Mrs. Cook continues to serve her community with her talent, energy and time; therefore be it

RESOLVED, That upon unanimous vote of the Board of Governors of the Florida Medical Association at its 111th annual Meeting in Hollywood, Florida, May 1-5, 1985, presents to Mrs. Gloria Cook its Distinguished Layman Award.

Medical Speakers Awards

The medical profession in Florida has benefitted in recent years from increased activity on the part of county medical societies and physicians in health-related television and radio programs.

This type of media activity is encouraged by the FMA. We established the Medical Speakers Awards to recognize some of these outstanding programs

and people who have made them successful. The First Place award winners receive a plaque and a check for $100.00. Second Place winners receive a framed certificate.

The First Place award for Organizational Television was presented to the Duval County Medical Society for their weekly program entitled *To Your Health*. This fifty-week series of programs represents a long-term commitment on the part of the Duval County Medical Society to give their community much needed medical and health information which helps the citizens better utilize the total health care delivery system. Dr. Jack L. Sapolsky, President of Duval County Medical Society, accepted the award.

The First Place award for Individual Television Performance goes to Dr. Joseph P. Fiore, of the Lee County Medical Society, last year's winner.

Dr. Fiore has been doing a series of weekly medical news segments entitled *To Your Health* since August of 1983. The program is aired regularly on the Fort Myers CBS affiliate, WINK-TV, as part of the local nightly news. This assures then a large viewing audience. Dr. Fiore devotes from eight to sixteen hours a week personally to this program. The award was accepted by Dr. Douglas A. Newland, President of Lee County Medical Society.

Second Place in the Individual Television Award went to Dr. Mitchell K. Schwaber of the Duval County Medical Society. Dr. Schwaber was cited for the excellent show he hosted concerning devices for the hearing impaired. This program was part of Duval County's *To Your Health* series. Dr. Jack L. Sapolsky accepted the award on behalf of Dr. Schwaber.

For the third year in a row, the winner in the Organizational Radio Category was the Duval County Medical Society. Their weekly call-in program entitled *Ask the Doctor* is broadcast over WEIX Radio in Jacksonville. Guest physicians talk about topics ranging from anesthesiology to urology. Once again, Duval County Medical Society is to be commended for their long-term commitment to the Medical/Health information needs of the Jacksonville community. Dr. Sapolsky accepted the award.

The final Speaker's Award, Individual Live Audiences, was presented to Dr. Lee A. Fischer of the Palm Beach County Medical Society. Dr. Fischer presented a talk entitled *Medicare HMO's: Get All the Facts Before Joining*. Over 2,000 people heard his presentation during the year at various Civic Clubs, churches and schools. His tireless efforts provided a real public service to the citizens of West Palm Beach. Dr. Fischer came forward to accept the award.

We would also like to extend our thanks to other medical groups around the state who submitted entries and encourage those of you who did not enter this year to enter next year. These programs, through your efforts, help to improve the image of the medical profession, for which we are all grateful.

At this time, Dr. Coleman presented the Harold S. Strasser, M.D., Good Samaritan Award to Richard Clemens Karl, M.D. of Tampa and Gaston J. Acosta-Rua, M.D. of Jacksonville.

Harold S. Strasser, M.D.
Good Samaritan Award
Richard Clemens Karl, M.D.

Whereas, Richard Clemens Karl, M.D., of Tampa, Florida, without concern for his own personal safety, welfare and comfort, committed an act of heroism beyond the call of his professional practice that saved the life of one of his fellow men; and

Whereas, While at work in the Tampa General Hospital, Dr. Karl went to the rescue of a despondent and suicidal patient who, despite security precautions, managed to get to a window with the obvious intention of leaping to his death; and

Whereas, Dr. Karl immediately intervened in this act of self-destruction by forcefully wrestling the patient from the window sill and into the safe confines of the room; and

Whereas, The confused and disoriented patient reacted violently, thrusting Dr. Karl aside and inflicting serious injury upon his person; and

Whereas, As a result of his altruistic act, Dr. Karl underwent decompressive laminectomy to his cervical spine and faces possible cervical fusion with prolonged halo type immobilization; and

Whereas, These injuries have caused Dr. Karl much pain and time lost from his practice; and

Whereas, Dr. Karl is a graduate of Cornell University Medical College and is presently the medical director of the H. Lee Moffit Hospital and Cancer Research Institute at the University of South Florida; and

Whereas, This physician humanitarian is a member of many medical organizations and is the author of many scientific articles and abstracts; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors of the Florida Medical Association, the Harold S. Strasser, M.D. Good Samaritan Award be presented at the 111th Annual Meeting in Hollywood, Florida, May 1-5, 1985, to Richard Clemens Karl, M.D., with sincere appreciation for his humanitarian acts on behalf of his fellow man.

Harold S. Strasser, M.D.
Good Samaritan Award
Gaston J. Acosta-Rua, M.D.

Whereas, Gaston J. Acosta-Rua, M.D., of Jacksonville, Florida, has upon a notable occasion demonstrated exemplary humanitarian efforts unselfishly and to the benefit of his fellow man without concern for his own safety, welfare or comfort; and

Whereas, In 1984, after driving several hours from the nearest large city to Ometepec, Mexico, Dr. Acosta-Rua assessed the situation of a patient who was paralyzed from the neck down due to a gun shot wound suffered the day before; and

Whereas, This patient was being ventilated via tracheostromy and ambu bag with only his family to take turns with the ventilating, Dr. Acosta-Rua decided to transport this patient to a larger city, utilizing his van as a make-shift ambulance; and

Whereas, After driving about an hour over mountainous roads, the van caught fire and the travelers were evacuated; and

Whereas, Without regard for his personal safety, Dr. Acosta-Rua re-entered the van and dragged the patient to safety; and

Medical Speakers Awards









(1) Jack L. Sapolsky, M.D., President of Duval County Medical Society, accepts First Place Organizational Television, (2) Douglas A. Newland, M.D., President of Lee County Medical Society, accepts Individual Television Performance, (3) Lee A. Fischer, M.D., Palm Beach County Medical Society, accepts Individual Live Audiences, and (4) Jack L. Sapolsky, M.D., President of Duval County Medical Society, received Second Place Individual Television Performance. Dr. Sapolsky accepted the award for Mitchell K. Schwaber, M.D., from FMA President, Frank C. Coleman, M.D.



Frank C. Coleman, M.D., FMA President, presents the Harold S. Strasser, M.D., Good Samaritan Award to Richard C. Karl, M.D., of Tampa.

Whereas, While caring for the patient on the road, the still burning van began to roll down the hill toward them and Dr. Acosta-Rua again moved the suffering patient to safety; and

Whereas, This distinguished individual makes annual trips to remote areas of Mexico to give needy residents medical care; and

Whereas, This generous gentleman is a member of the American Medical Association, a member of the House of Delegates of the Florida Medical Association, a member of the Florida Neurological Society, a member of the Congress of Neurological Surgeons and a member of the Governing Board of Northeast Florida Health Agency; and

Whereas, Dr. Acosta-Rua is a member of the Meninak Club, the October Club, The Hispano-American Cultural Association and the Cuban-American Club; and

Whereas, Dr. Acosta-Rua was born in Cardenal, Cuba, and is a graduate of Havana University Medical School and Madrid University Medical; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 111th Annual Meeting in Hollywood, Florida, May 1-5, 1985 present to Gaston J. Acosta-Rua, M.D., the Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for his humanitarian acts on behalf of his fellow man.



Frank C. Coleman, M.D., FMA President, presents the Harold S. Strasser, M.D., Good Samaritan Award to Gaston J. Acosta-Rua, M.D., of Jacksonville.

Presentation of the "Ruth Balle Resolution" was presented to Howard W. Pettengill, M.D., of Melbourne on behalf of Mrs. Ruth Balle with a duplicate award presented to Brevard County Medical Society also accepted by Dr. Pettengill.

Ruth Balle Recognition

Whereas, Ruth Balle has served with dignity, pride, and exceptional ability as Executive Director of the Brevard County Medical Society since 1966; and

Whereas, Ruth Balle has been a true friend to organized medicine and to the goals of all physicians and their families; and

Whereas, Ruth Balle has worked untiringly for the Brevard County Medical Society, making it a most respected and effective component of the Florida Medical Association; and

Whereas, Ruth Balle became a personal friend to many other county executive officers, to the Florida Medical Association staff, and to many physicians through the state including state officers who all held her in high regard; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to this outstanding lady of medicine, Ruth Balle, who has served our profession with dignity, pride, ability, and tender loving care; and be it further

RESOLVED, That a copy of this resolution be delivered to Ruth, in the form of a certificate, and a copy be rendered to the Brevard County Medical Society office and it members.

Mike Lopez Resolution

Mrs. Kathy Lopez, escorted by Dr. William J. Ramanos, President of Palm Beach County Medical Society and Dr. Lee Fischer, Palm Beach, accepted the "Mike Lopez Resolution."

Resolution — Michael H. Lopez, Jr.: The Board expressed deep regret over the sudden and unexpected death of Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society, and adopted the following resolution:

Whereas, Mike Lopez met an untimely death on December 22, 1984; and

Whereas, Mike Lopez was a steadfast friend of organized medicine and to all physicians and physicians' families; and

Whereas, Mike Lopez worked untiringly for the Palm Beach County Medical Society making it one of the most respected and effective component medical societies; and

Whereas, Mike Lopez was a personal friend to many members of organized medicine; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to Mike for his many contributions to organized medicine, and send a report of this action to his family in an expression of our deepest condolence.

1985 Awards for Excellence In Medical Journalism

Dr. Coleman then presented the Eighth Annual Florida Medical Association Awards For Excellence in Medical Journalism. This past year was an exciting and eventful one in the field of medicine, actively covered by journalists all over the state. How



Dr. Coleman presented to Mrs. Kathy Lopez a resolution honoring Michael H. Lopez Jr., Executive Vice President of Palm Beach County Medical Society.

eventful is illustrated by the entries in this awards contest. They cover a broad range of subjects, from Alzheimer's Disease to trauma treatment. New life-saving treatments made possible by modern medical technology were brought into public view, as were the issues of the "Bionic Body."

The purpose of this awards program is to recognize and thank journalists for their efforts and to encourage outstanding and responsible medical reporting.

The entries were judged by two panels of judges. The newspaper and magazine articles were judged by: John E. Ropp, President of Ropp Advertising; Roger Langston, General Manager, Centurian Press; Hank Drane, Media Consultant, FMA Communications; and Frederick W. Hartmann, Executive Editor, *Florida Times-Union*. The radio and television categories were judged by Dr. Patricia Cowdery of Jacksonville; Dr. F. Norman Vickers of Pensacola; Louis J. DiGiusto of the Florida Production Center and James A. Richardson, Director of Communications for FMA. We certainly would like to thank the judges for donating their valuable time to these awards.

Our First Place winners this year are from Dade, Alachua, Charlotte and Indian River Counties. Each winner in the six categories — Radio, Television, Newspapers, with circulation over 50,000, Newspapers with circulation under 50,000, Weekly Newspapers and Magazines — will be presented with a trophy and a check for $500.00.

The first award was in the Radio category. This year's first place entry was a feature news story entitled "More Than One Too Many — Habitual Drunk Drivers in South Florida." The story was presented by Frank Mottek of WINZ AM of Miami.

The death of a local teenage boy sparked a lot of controversy in Miami and pointed out the need for a trauma network in South Florida. Diana Gonzalez-Durruthy and Al Durruthy of WPLG-TV, Miami, put together an exhaustive, in-depth five-part series entitled "Trauma — When Seconds Count." This series earned them first place in our televsion category.

The next winner in the newspaper over 50,000 circulation was Mr. Horance G. "Buddy" Davis. "The Battle of Wounded Heart" was a gripping six-part account of Mr. Davis' experience with the medical care delivery system after suffering acute myocardial infarction. As he stated in article, "I died something like four times last October. Dying is a weird and depressing experience, leavened only by admiration for the alertness and skill of those who pounded life back into a spent shell."

Sam Rohlfing, a repeat winner in the newspaper under 50,000 circulation, could not be in attendance because of a long-planned out-of-the-country trip. She won the award again because of her consistently outstanding monthly health feature entitled, "Your Health" which appears in the *Vero Beach Press-Journal*. Donald L. Ames, M.D., Vero Beach, accepted the award on behalf of Sam Rohlfing.

The winner in the weekly newspaper category was also a repeat winner from last year. Gene Casey of the *Charlotte Sun* was unable to attend last year's awards because he was undergoing an operation and treatment for Stage 4 oral cancer. Given a 50-50 shot at survival, Gene Casey made two decisions: "To Fight Like Hell To Survive" and to record the experience in his weekly page-one column in the *Charlotte Sun*. He accomplished both feats with remarkable success.

Our final category was magazines. Fraser Kent of the *Miami-South Florida Magazine* was awarded first place for his in-depth article entitled, "At Last: Good News About Cancer." This article looked at the tremendous strides being made in cancer research, diagnosis and treatment. Mr. Kent won second place in this category last year. We would like to congratulate him for doing a consistent outstanding job in medical journalism.

One of the above winners, judged the best of all entries, received the Ernest R. Currie Memorial Media Award which memorializes the Duval County Medical Society's Executive Vice President who served from 1968 until his death in 1984. Mr. Currie became involved in organized medicine following a successful career in broadcasting. He effectively utilized his expertise in the media to further the cause of medicine by establishing both a radio and a cable television program for the medical society and a weekly newspaper column. The First Annual Ernest R. Currie Memorial Media Award was presented to Mr. Horance G. "Buddy" Davis of the



Dr. Coleman presented the First Annual Ernest R. Currie Memorial Media Award to Mr. Horance G. "Buddy" Davis of the *Gainesville Sun*.

Gainesville Sun for his series entitled "Battle of Wounded Heart."

The Second Place Awards as well as the Honorable Mentions, consisting of a certificate and a check for $200, will be presented by the appropriate county medical society at a later date. Dr. Coleman then announced these winners.

In Radio, Second Place went to Rebecca Randall of WDBO, Orlando, for her feature news report entitled "The Catastrophic Disease".

Second Place in Television was awarded to Art Carlson of WPLG-TV in Miami for his three-segment work entitled "The Body Bionic," "Biofeedback and Paralysis," and Refractive Surgery."

Due to the extremely high quality of television entries, the judges awarded three Honorable Mentions. An Honorable Mention for Community Service went to Adele Tyre of WTSP-TV, St. Petersburg for her entry, "An Age Old Fear: Alzheimer's." Other Honorable Mention Awards goes to Bret C. Snyder, Leisa Zigman and Ron Krauss, WUFT-TV, Gainesville, for their entry "Emptying the Warehouses: Florida's Cluster Home Projects" and to L.J. Haney, C.W. Craig and Mitchell Haley of Lee Memorial Hospital Media Services, Ft. Meyers, for their entry, "Medical Digest."

Second Place in daily newspapers with circulation over 50,000 went to Shari Roan of the *Ft. Lauderdale News & Sun Sentinel* for her article "Toxic Shock Syndrome: A Case of Neglect" and to Tom and Pam O'Hara of the *Miami Herald* for their feature "In Sickness and In Health."

Second Place in newspapers with under 50,000 circulation was awarded to Susan Peterson of the *Sun-Tattler*, Hollywood, for her article "Human Genetics."

Tom Denhaver of *The Sun* in Sun City Center was awarded Second Place in the weekly newspaper category for his article "HMO — Cure or Cancer."

Second Place in Magazines went to Rosemary Gondreau of the *Orlando Sentinel* for her feature story entitled, "Felicia's Story."

Sanford A. Mullen, M.D., Award

President Coleman called on Wayne Schrader, M.D., President of the Florida Society of Pathologists, to present the fourth annual Sanford A. Mullen, M.D., Award. Dr. Schrader presented the award to Lawtey E. McHenry, M.D. Board certified in both clinical and anatomical pathology as well as nuclear medicine, Dr. McHenry has served twice as President of the Florida Society of Pathologists. He is a delegate to the College of American Pathologists and a Board member of the American Society of Clinical Pathologists. He has served as Medical Examiner for Brevard County since 1964, and in 1972 was appointed District Medical Examiner by the Governor of Florida.

Corrections to the Handbook were then announced by the Vice Speaker:

Several County Medical Society Presidents had changed since the Handbook was printed. The list of Privilege of the Floor was changed appropriately.

The Speaker then recognized several officers of the FMA Auxiliary who were present: Mrs. Jo Tignor, President-Elect, Mrs. Sandy Whittaker, Secretary, and Mrs. Priscilla Gerber, 1985-86 AMA-ERF Chairman.



Dr. Lawtey E. McHenry (left) accepted the Sanford A. Mullen, M.D., Award from Florida Society of Pathologists President, Dr. Wayne Schrader (right).

Presentation by Auxiliary President Mrs. Laurin G. (Nancy) Smith

Thank you. Dr. Coleman, FMA members and guests. The Florida Medical Association Auxiliary has been in action all year and I am pleased to announce some of our many accomplishments. Our second annual Media Day was held in October. We had varying degrees of success around the state, but we felt we were successful in opening the eyes of the journalists to the activities and the participation of medical families.

Our Committee on Aging worked overtime. Working closely with the Florida Medical Association, our Public Relations Chairman, the Medi-File was designed by Auxilian Ann Swing and distributed at Fall Conference. Adele Graham, the Governor's wife, endorsed our Medi-File by making a public service announcement on television which has run frequently around the state. We have also been asked by fourteen other states to use our Medi-Files in their home states. We have also attended the Governors's Commission on Aging and at this time are actively supporting legislation on Alzheimer's Disease. Our Special Auxiliary Issue of *The Journal of the Florida Medical Association, Inc.*, featured aspects of aging from a new and creative angle. The articles were up-beat and educational, giving emphasis to the healthy older adult and emphasizing positive contributions this growing segment of our population represents. After the FMA Auxiliary won the national award last year for the most monies ever collected for AMA-ERF, we were frightened that this year would be somewhat of a let down. On the contrary, all the counties have pulled together and I believe we might just pull it off again. At this moment, we have $111,000 and all the figures are not in yet. And, we have renewed interest in health career activities. Lee County showed us with the formation of a $650,000 grant for endowed share of nursing at the University of South Florida, Ft. Myers, that we can make a critical difference. I might add less than 12 women worked on the project and they raised that money in less than three months. Broward County also receives real credit for the $14,500 they put together for scholarships this year. The Auxiliary feels the need for well trained personnel in the allied health field. This need is especially great in Florida, where because of the rising population, health care is predicted to be the number one industry in the state. From our educational projects to our legislative activities, to our quarterly magazine and to our internal projects which advanee the Auxiliary's goal of promoting friendlier relationships among medical families, we are proud of our year and we are especially proud of the warm cooperative relationship we have with the Florida Medical Association.

Thank you.



Dr. Coleman was presented a plaque symbolic of his up-hill battle during his tenure as FMA President.

Dr. Perry announced that in the interest of time the names of the members of the Reference Committees who were appointed and assigned would not be read. However, they were listed in the Handbook and would be introduced individually when they gave their reports and at the time of their presentations in front of the various members of the Association. Dr. Perry then announced the times that each Reference Committee would meet.

Reference Committee No. I Health and Education

Alvin E. Smith, M.D., Chairman, Volusia
Gaston Jose Acosta-Rua, M.D., Duval
Robert B. Peddy, M.D., Polk
Hector Mendez, M.D., Orange
Dolores A. Morgan, M.D., Dade
Douglas A. Newland, M.D., Lee
AMA Delegate Advisor: Richard G. Connar, M.D.
(Alternate — Charles J. Kahn, M.D.)

Reference Committee No. II Public Policy

Luis R. Guerrero, M.D., Chairman, Palm Beach
Michael R. Redmond, M.D., Escambia
Charles S. Eytel, M.D., Collier
Wallace M. Philips Jr., M.D., Orange
Harold G. Norman, M.D., Dade
Paul A. Flaten, M.D., Broward
John W. Glotfelty, M.D., Polk
AMA Delegate Advisor: Robert E. Windom, M.D.
(Alternate — Joseph T. Ostroski, M.D.)

Reference Committee No. III Finance and Administration

Margaret C. S. Skinner, M.D., Chairman, Dade
James T. Cook III, M.D., Bay
John C. Moore, M.D., Polk
Virgil A. Ponzoli Jr., M.D., Collier
Robert H. Hux, M.D., Lake
Glenn S. Hooper, M.D., Hillsborough
AMA Delegate Advisor: T. Byron Thames, M.D.
(Alternate — O. William Davenport, M.D.)

Reference Committee No. IV
Legislation and Miscellaneous

Kenneth C. Kiehl, M.D., Chairman, Sarasota
David R. Arrowsmith, M.D., Okaloosa
Thomas R. Busard, M.D., Manatee
E. Joan Barice, M.D., Palm Beach
Charles A. Dunn, M.D., Dade
Arnold L. Tanis, M.D., Broward
Samuel L. Renfroe, M.D., Marion
AMA Delegate Advisor: Louis C. Murray, M.D.
(Alternate — Sanford A. Mullen, M.D.

Reference Committee No. V
Medical Economics

Charles P. Hayes Jr., M.D., Chairman, Duval
John M. Canakaris, M.D., Flagler
Robert L. Dawson, M.D., Pinellas
Alan J. Yesner, M.D., Broward
Charles B. McIntosh, M.D., Duval
Miguel Figueroa, M.D., Dade
Ralph E. Rydell, M.D., Hillsborough
Jack W. MacDonald, M.D., Capital
AMA Delegate Advisor: Joseph C. Von Thron, M.D.
(Alternate — Dick L. Van Eldik, M.D.

Dr. Perry announced that the assignments of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignments of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates packets as indicated on the reports.

The Speaker called for any reports which had were received too late to be included on the agenda. The Council on Hospital Medical Staffs met for the first time and were unable to submit their resolution by 12:00 noon and according to the Bylaws, all resolutions received after 12:00 noon must have an unanimous consent of the House. The motion to consider this resolution passed.

Dr. Perry announced the dates and times of the Auxiliary Reception and Art Auction, Blue Cross and Blue Shield Informational Meeting, Florida Physicians Association Annual Membership Meeting, the General Session, Tee-off time for the Golf Tournament, the FMA Symposium "Quality Medicine in a Rapidly Changing Environment," the President's Reception, the FLAMPAC/Auxiliary Luncheon, and the Health Run.

The House recessed at 6:00 p.m. to reconvene on Saturday, May 4, at 3:00 p.m.

President's Reception

(1) Dr. and Mrs. Joseph C. Von Thron (2) Dr. and Mrs. George S. Palmer (3) FMA President Dr. Frank C. Coleman and Mrs. Ruth Coleman (4) Left to right: Dr. Luis M. Perez, President-Elect, Dr. Maria Perez, Mrs. Ruth Coleman, and Dr. Frank C. Coleman, President (5) Dr. and Mrs. A. Frederick Schild are greeted by President-Elect Dr. Luis M. Perez and Dr. Maria Perez (6) Dr. and Mrs. Rufus K. Broadaway (7) FMA Staff Members (left to right) Ms. Joann Gore, Ms. Sara Karppe, and Ms. Debbie Graft (8) Dr. and Mrs. A. Frederick Schild all enjoy the Annual President's Reception.

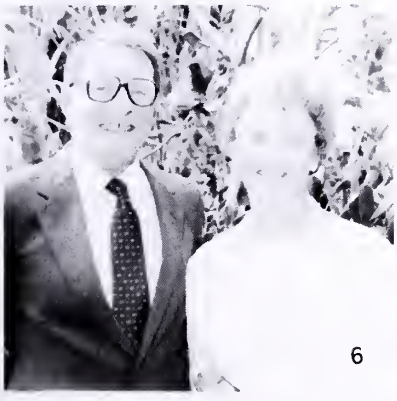

1


2


3


4


5


6


7


8

Editor's Dinner


1


2


3


4


5


6


7


8


9

This year's Editor's Dinner was the last for the Editor, Daniel B. Nunn, M.D., who served as Editor for five years. (1) Left to right: Mrs. Ruth Coleman, President Frank C. Coleman, Dr. Nunn, President-Elect Dr. Luis M. Perez, Dr. Maria Perez (2) Two past Editors (left to right) Dr. Gerold L. Schiebler, Dr. Clyde M. Collins and Dr. Nunn (3) Dr. Nunn and Dr. E. Charlton Prather (4) Dr. Nunn was presented a plaque from the Board recognizing his accomplishments as Editor for the past five years (5) Dr. and Mrs. Lee Fischer enjoy the Editor's Dinner (6) Dr. T. Byron Thames (7) Dr. Clyde M. Collins (8) Dr. R. G. Lacsamana (9) Dr. Robert C. Fore all pay tribute to Dr. Nunn.

General Session

The General Session of the 111th Annual Meeting of the Florida Medical Association, Inc., was called to order at 11:10 a.m. on Friday, May 3, 1985, in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida.

Dr. Coleman introduced the officers seated at the head table and then recognized certain distinguished guests.

Dr. Coleman then invited Dr. Luis M. Perez, President of the Florida Medical Foundation and Mrs. Nancy Smith, President of the FMA Auxiliary to come to the podium for the presentation of grants from the AMA-ERF to medical school deans. Mrs. Smith introduced Mrs. Joan Selander, State AMA-ERF Chairman.

Checks were presented to Dr. William B. Deal, Dean, University of Florida, College of Medicine, Gainesville; Dr. Bernard J. Fogel, Dean, University of Miami, School of Medicine, Miami; Dr. Andor Szentivanyi, Dean, University of South Florida, Tampa. Dr. William B. Deal accepted the check on behalf of The Program in Medical Sciences, Florida State University.

After these presentations, Mrs. Smith made a special presentation to Dr. Perez of a check for $5330.16 for the Impaired Physicians Program of the Florida Medical Foundation. Mrs. Smith introduced Mrs. Charlotte Wright, State FMF Chairman.

Dr. Coleman then announced the winners of the 1985 Scientific Exhibit Awards.

1985 Scientific Exhibit Awards

First Place:
"An Early Approach to Correction of Severe Facial Deformity by Combined Cranio-Facial Surgery"
Mutaz B. Habal, M.D., Tampa

Second Place:
"Cocaine Abuse: Detection and Treatment"
Irl Extein, M.D.

Third Place:
"Gastric Restrictive Surgery (Stapling) for Morbid Obesity — Experience of 800 Cases"
Alex M. MacGreggor, M.D., Gainesville

Honorable Mention:
"Flexible Sigmoidoscopy — Why and How?"
John P. Christie, M.D., South Miami

"Preserving Tissue in Fingertip Injuries"
Merlin Anderson, M.D., Tampa

"Help for the Totally Deaf — The Cochlear Implant"
Frederic W. Pullen II, M.D., Miami

On behalf of Dr. Daniel B. Nunn, Editor of *The Journal*, Dr. Pierre J. Bouis Jr., announced the winner of the Editor's Award which is presented annually to the best entry in the Auxiliary Art Show. This year's winning entry was "Purple Vein" by Michele Schiebler, Gainesville. The winning entry traditionally appears on the cover of the Proceedings Issue of *The Journal*.

Dr. Bouis then announced the winners of the Eighth Annual JFMA Awards Contest For County Medical Society Bulletins.

Winners of Eighth Annual JFMA Awards Contest For County Medical Society Bulletins

Category 1 — General Excellence
First Place: Volusia County *The Stethoscope*
R. G. Lacsamana, M.D., Editor

Special Citation: Dade County *Miami Medicine*
Richard J. Feinstein, M.D., Editor

Category II — Most Improved Bulletin
First Place: *Hillsborough County Bulletin*
John E. Perchalski, M.D., Editor

Special Citation: *Escambia County Bulletin*
F. Norman Vickers, M.D., Editor

Category III — Best Editorial
First Place: Dade County *Miami Medicine*
Richard J. Feinstein, M.D., Editor

Special Citation: *Marion County Bulletin*
Henry L. Harrell Jr., M.D., Editor

Category IV — Best Regular Feature
First Place: *Lee County Bulletin*
F. Lee Howington, M.D., Co-Editor
Kim Spear, M.D., Co-Editor

Category V — Special Recognition
First Place: *Polk County Bulletin*
John W. Glotfelty, M.D., Editor



Dr. James H. Sammons, Executive Vice President of the American Medical Association, presented the annual Baldwin Lecture.

Dr. Coleman then introduced the 1985 Abel S. Baldwin lecturer, Dr. James H. Sammons, Executive Vice President of the American Medical Association.

Dr. Sammons is recognized as one of the nation's leading spokesmen on health issues. In a poll conducted by *U.S. News and World Report*, leaders ranking their peers placed Dr. Sammons first in the prestigious list of decision makers in the American health care field.

Dr. Sammons began his remarks by reminding physicians that they and Dr. Baldwin in 1874 had in common the physician-patient relationship which results in "expressions of faith." "Patient selection of a physician," Dr. Sammons explained, "and physician acceptance of a patient, also constitute the expression of a mutual faith, and it can be essential to the cure."

Dr. Sammons stated that preserving this faith is one of AMA's foremost priorities, along with preserving the excellence of medical education and patient care delivery system. The progress medicine has made since 1874 has created many problems, he went on, concerning ethical and legal issues involving treatment. Because the American public expects perfect results from medicine, physicians are being taken to court when the perfect result is not achieved, resulting in a professional liability insurance crisis.

"Modern medicine also is high cost medicine," Dr. Sammons said, "so in health care, cost restraint has become the number one song on the nation's legislative and regulatory charts with private and public payers singing in the chorus." Dr. Sammons explained that "we use the abiding faith in our own profession to help ourselves and ultimately our patients and society at large" when dealing with DRG's, PRO's, and other cost containment programs. The AMA has programs available to help physicians and their staffs to function more efficiently and competitively in the marketplace, he added as well as a program that provides demographic information about a location to aid physicians who are just starting or relocating their practices.

Dr. Sammons also described the AMA's new Special Task Force on Professional Liability, whose reports and recommendations for action have been commended by newspapers such as *The Chicago Tribune* and *USA Today*. After describing problems associated with DRG's, PRO's and other cost-containment programs, Dr. Sammons assured his listeners that the AMA was keeping a close watch on all these programs. He expressed his disbelief that the "people of this country will allow undue damage be done to a medical and health services system to provide them with the best kind of care." He added, "We shouldn't provide more care than is really needed, but we will insist on providing as much as is really needed. With our profession that too is an article of faith."

Eighth Annual JFMA Awards Contest



1

Seven county medical societies received plaques in the Eighth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. The awards were presented at the annual Editor's Dinner. (1) Dr. John E. Perchalski, Editor, Hillsborough County Bulletin accepts the award for Most Improved Bulletin (2) Dr. A. Frederick Schild accepts the Best Editorial Award for Miami Medicine, on behalf of the Editor, Dr. Richard J. Feinstein (3) Dr. John W. Glotfelty, Editor, Polk County Bulletin accepts the Special Recognition Award (4) On behalf of Dr. F. Norman Vickers, Editor, Escambia County Bulletin, Dr. Henry M. Yonge accepts the Special Citation in the Most Improved Bulletin category (5) Dr. R. G. Lacsamana, Editor, Volusia County Bulletin accepts the award for General Excellence (6) Mrs. Ann Wilke, Executive Secretary of Lee County Medical Society, accepts the award for Best Regular Feature for Drs. F. Lee Howington and Kim Spear (7) Dr. Henry L. Harrell Jr., Editor, Marion County Bulletin accepts a Special Citation in the Best Editorial category.



2



3



4



5



6



7

Annual Meeting Highlights













(1) Dr. and Mrs. Frank C. Coleman greet Andor Szentivanyi, M.D., Dean of the University of South Florida College of Medicine (2) Past President J. Lee Dockery, M.D., and his wife Barbara (3) President-Elect Luis M. Perez, M.D. (center) welcomes his sons Hector "Tico" (left) and Luis M. Perez Jr. (right) (4) FMA Executive Director Donald C. Jones (right) welcomes Laurin G. Smith, M.D., and Mrs. S. Bruce (Priscilla) Gerber (5) Dr. and Mrs. Emmet F. Furguson Jr. (left) and JFMA Editor Daniel B. Nunn, M.D., and Mrs. Nunn (Gloria) (6) FMA Past Presidents (left to right) O. William Davenport, M.D., Vernon B. Astler, M.D., T. Byron Thames, M.D., and Joseph C. Von Thron, M.D.













(7) FLAMPAC President Robert E. Windom, M.D. (left), Laurin G. Smith, M.D., Vero Beach, and Douglas Kiker, NBC News Correspondent (8) FMA Staff (left to right) Sissy Crabtree, Janice Danson, Bob Harvey, Lee Pass, and Marcia Protheroe (9) Annual Health Fun Run (10) FMA Staff at Delegate Registration. Left to right, Lee Pass, Cindy Curry, and Marcia Protheroe (11) Dr. and Mrs. Frank C. Coleman and Past JFMA Editor Clyde M. Collins, M.D., (right) (12) Jere W. Annis, M.D., and (right) Past President Samuel M. Day, M.D.

Second House of Delegates

The Second House of Delegates convened at 3:15 p.m., Saturday, May 4, 1985 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida with Dr. James B. Perry, Speaker of the House, presiding.

Dr. Gerald Stoker of the Credentials Committee reported that 221 Delegates were present with 36 component county societies represented, constituting a quorum, and moved that the Delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Elayne E. Cassisi, M.D.; Robert K. Casey, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; Gerold L. Schiebler, M.D.; Michael Fagien, Student Delegate.

BAY — James T. Cook III, M.D.; Terrence R. Steiner, M.D.; (Absent — B. Philip Cotton, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Antonio Catasus, M.D.; Brian J. Ellis, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; George P. Mesenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — Phillip A. Caruso, M.D.; George J. Crane, M.D.; Arthur L. Eberly, M.D.; Theodore W. Hahn, M.D.; David C. Lane, M.D.; Joseph M. Sachs, M.D.; Donald D. Sheffel, M.D.; Marvin L. Stein, M.D.; Juan S. A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Clarence M. Harris, M.D.

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Nanjunda Swamy, M.D.

DADE — Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Barbara Drabkin, M.D.; Charles A. Dunn, M.D.; Byron D. Epstein, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Simon Frank, M.D.; Antonio F. Frexes, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Marraccini, M.D.; Miguel A. Mora, M.D; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; William I. Roth, M.D.; Oscar Sandoval, M.D.; A Fredrick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Charles F. Tate, M.D.; Emilio A. Trujillo, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Edward R. Annis, M.D.; Harlon S. Chiron, M.D.; N. Ralph Frankel, M.D.; Samuel P. Stokley, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.; Jack L. Sapolsky, M.D.: Sedbury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — William P. Booras, M.D.; Daniel B. Nunn, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — C. Fenner McConnell, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HILLSBOROUGH — Richard J. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Greiwe, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas E. McKell, M.D.; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate.)

INDIAN RIVER — Paul A. Graham, M.D.; Kip G. Kelso, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.; Stephen R. Zellner, M.D.; (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Robert A. Meyer, M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; George E. McLain, M.D.

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thomp son, M.D.

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Edward Farrar, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Phillips, M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Henry J. Baskin, M.D.; David L. Mackey, M.D.; Robert N. Serros, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; George L. Ford, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Gilbert R. Panzer, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Robert Burger, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Vincent Cotroneo, M.D.; Carl W. Graves, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; (Absent — Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — Edward D. Risch, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; David L. Fromang, M.D.; (Absent — Manuel G. Garcia, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; Richard J. Beebe, M.D.; John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Ernest C. Smith Jr., M.D.; David L. Thomas, M.D.; (Absent — Robert W. Dein, M.D.)

SEMINOLE — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — Harry F. Farmer, M.D.; Martin S. Feigenbaum, M.D., Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF THE HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Dr. Perry requested that Dr. Coleman announce the winners of the FMA Golf Tournament. First Place was Vernon B. Astler, M.D. and Second Place was James G. White, M.D.

Dr. Coleman also announced the winners of the 1985 Health Run. In First Place with a running time of 20:16 was Mr. George Markovich; Second Place with a running time of 20:19 was Dr. John Hartman; and Third Place with a running time of 20:44 was Dr. Richard Garcia.

Dr. Coleman then announced the Technical Exhibit Winners. In First Place was Dr. Joan Harris; Second Place was Loyce Glass; and Third Place was Edward W. Stoner.

Dr. Perry then recognized Dr. David Thomas, Dr. Bernard Kimmel, and Dr. "Doc" Myers. Dr. Perry also asked that recognition in the form of applause be given to the Reference Committees for the responsibility, difficulty, and complexity involved this year in preparing the reports.

Report of Reference Committee No. 1 Health and Education

Dr. Perry called the Chairman and members of Reference Committee I, Health and Education, to present the Report.

Dr. Alvin E. Smith, Chairman, and his Committee came forward to present the report of Reference Committee I, Health and Education.

Report of the Council on Scientific Activities

The Report of the Council on Scientific Activities was adopted.

The Council on Scientific Activities has had an extremely active year meeting four times in conjunction with meetings of component committees and subcommittees. Council and committee business began on May 5, 1984 in Lake Buena Vista, with preliminary plans for the 111th Annual Meeting in Hollywood. Subsequent meetings were held on September 7, 1984 in Tampa; November 16, 1984 in Orlando; and February 1, 1985 in Tampa. The Council's work is summarized under the heading of each committee and subcommittee.

Committee on Medical Education

Orris O. Rollie, M.D., Orlando, has completed a highly successful year as Chairman of the Committee. Major activities of the Committee have centered on the 111th Annual Meeting Scientific Program, ACCME accreditation of hospital continuing medical education programs, approval of Florida Medical Association mandatory credit for CME providers, and the issue of foreign medical graduates.

Subcommittee on Annual Meeting Scientific Program

Under the leadership of Ira B. Harrison, M.D., Tallahassee, the Subcommittee has again produced an outstanding scientific program for the 111th Annual Meeting in collaboration with FMA recognized specialty groups. Several highlights of the scientific program will be a symposium entitled "Quality Medicine in a Rapidly Changing Environment", and specialty programs on Bioethics and "The Basics of Searching Medline." Additional attractions will include sections on chemical dependency, workers' compensation, a special symposium on aging, Wyeth Programmed Auto Tutors, and many technical, scientific and educational exhibits.

Once again, the Annual Meeting Scientific Program will offer a total of 20 hours of AMA Category I approved continuing medical education credit. Additional co-sponsorship by the Colleges of Medicine of the University of South Florida, University of Miami, and the University of Florida will be included.

For the second year, the FMA Leadership Conference included a scientific program on Friday afternoon. World renown medical author and researcher, Robert A. Good, M.D., presented a one-hour program entitled "Clinical and Fundamental Approaches to Cellular Engineering" which was well attended and received highly favorable evaluations.

Subcommittee on Accreditation

Samuel E. Crockett, M.D., Orlando, has continued his effective leadership as Chairman of this Subcommittee. A comprehensive manual entitled *Continuing Medical Education: Essentials for Accreditation* was published and provided to every accredited organization in Florida. Interest in ACCME accreditation continues to increase and the following actions have been taken since the last Annual Meeting.

— **Baptist Medical Center,** Jacksonville — Reaccredited for a six-year period, January 13, 1984 through January 12, 1990.
— **The Good Samaritan Hospital,** West Palm Beach — Reaccredited for a six-year period, June 27, 1984 through June 26, 1990.
— **North Ridge General Hospital,** Ft. Lauderdale — Reaccredited for a six-year period, November 21, 1983 through November 20, 1989.
— **Parkway Regional Medical Center,** North Miami Beach — Reaccredited for a two-year provisional period, December 17, 1984 through December 15, 1986.
— **Sarasota County Medical Society,** Sarasota — Reaccredited for a six-year period, December 12, 1984 through December 11, 1990.
— **South Florida Psychiatric Society,** Miami — Reaccredited for a six-year period, May 25, 1983 through May 24, 1989.
— **Veterans Administration Center,** Bay Pines — Reaccredited for a two-year period, February 29, 1984 through February 28, 1986.

Subcommittee on Program Approval

Chairman David S. Hubbell, M.D., St. Petersburg, and his Subcommittee have continued to provide outstanding service to CME providers in Florida who have sought FMA mandatory credit for their programs. After programs are reviewed and approved by county medical society CME Chairmen, selected members of the Subcommittee evaluate applications and award credit if approved. In 1984, over 1300 hours of FMA mandatory credit were awarded in 380 separate programs.

Committee on Scientific Publications

Daniel B. Nunn, M.D., is completing his fifth and final year as Editor of the *Journal of the Florida Medical Association, Inc.*, and Chairman of the Committee on Scientific Publications. Since becoming Editor in June of 1980, the *Journal of the Florida Medical Association, Inc.* has published 19 special issues, 369 scientific



Reference Committee I (Health and Education) was chaired by Alvin E. Smith, M.D., Ormond Beach. Left to right: Charles J. Kahn, M.D., Pensacola; Richard G. Connar, M.D., Tampa; Douglas A. Newland, M.D., Fort Myers; Hector R. Mendez, M.D., Orlando; Miss Dawn Bouchard, Recorder; Dr. Smith; Gaston Jose Acosta-Rua, M.D., Jacksonville; Robert B. Peddy, M.D., Lakeland; Dolores A. Morgan, M.D., Miami Beach; Ernest C. Smith, M.D., Englewood.

articles, 71 special articles and 100 editorials. Included in these statistics are 873 authors. An illustration of the high quality of the JFMA during Dr. Nunn's tenure was recognition by the Sandoz Pharmaceutical Company in 1983 as the First Place Winner in the State Medical Journal Category of their Annual Medical Journalism Awards Contest.

Report of the Council on Specialty Medicine

The motion of the Reference Committee that the Report of the Council on Specialty Medicine be adopted as presented except for those portions referred to other Reference Committees carried.

The Council on Specialty Medicine held three meetings during the 1984-85 Association Year: July 21, 1984; September 29, 1984; and February 23, 1985. The Subcommittee on Recognition for Specialty Groups held meetings in conjunction with all three Council meetings.

The Council on Specialty Medicine is comprised of 38 FMA recognized specialty groups representing all major areas of medical practice. Many different issues were considered by the Council during the Association year. Major issues included:

1. **Florida Society of Ophthalmology, Inc.:** The Council recommended that the FMA approve the recommended legislative objectives submitted by the Florida Society of Ophthalmology and that they be included in the 1984-85 legislative program of the Florida Medical Association.
2. **Florida Society of Anesthesiologists:** The Council recommended that the FMA approve the recommended legislative objectives submitted by the Florida Society of Anesthesiologists and that they be included in the 1984-85 legislative program of the Florida Medical Association.
3. **Naturopathic Practice:** The Council recommended that the FMA support any legislative activities prohibiting any further licensing of naturopathic practices.
4. **House of Delegates Voting:** The Council recommended that each member of the Council on Specialty Medicine, or their designated alternate be allowed to have one vote in the FMA House of Delegates.
5. **Medicare Freeze:** The Council recommended that the FMA endorse the American Medical Association lawsuit questioning the constitutionality of the Medicare law and that the FMA urge the AMA to seek an injunction prohibiting enforcing the Medicare freeze until a federal lawsuit has been heard. The Council also recommended that FMA urge the AMA to have Congress enact a law negating the provisions of the Deficit Reduction Act pertaining to Medicare reimbursement.
6. **Licensing of Physicians:** The Council recommended that the FMA strongly oppose any legislation that would allow in special cases for physicians to bypass state licensing boards to practice medicine in Florida.
7. **Liaison Committee to PIMCO:** The Council recommended that the FMA authorize the Florida Physicians' Insurance Reciprocal Liaison Committee to conduct a thorough and detailed analysis of all existing data and reports that are available on the Reciprocal up until the time the Reciprocal was put in rehabilitation and to report its findings to the FMA membership.
8. **Terminally Ill Patients:** The Council recommended that the FMA conduct a review of all existing policies of the AMA and FMA pertaining to the withdrawal or withholding of medical care for terminally ill patients and that the highlights and legal implications of this study be directed to the attention of the FMA membership.
9. **Confidentiality of Patient Records:** The Council recommended that the FMA oppose any legislation or requests that allow for the release of confidential patient records and support the guidelines adopted by the Florida Council of District Branches of the American Psychiatric Association.
10. **Specialty Group Recognition:** The Council approved continuing recognition for the following specialty groups which have met the criteria established by the FMA House of Delegates:

 Florida Society of General Surgeons
 Florida Society of Rheumatology
 Florida Society of Clinical Oncology
 Florida Society of Dermatology
 Florida Gastroenterologic Society
 Florida Society of Neonatal Perinatologists
 Florida Society of Neurology

Florida Orthopedic Society
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society
Florida Society of Pathologists
Florida Endocrine Society
Florida Society of Physical Medicine and Rehabilitation

11. **Criteria for Specialty Group Recognition:** The Council recommended elimination of the recognition program criterion requiring specialty groups to participate in the FMA Annual Meeting Scientific Section once during a three year period.
12. **Mandatory Seat Belt Bill:** Upon careful study of the AMA's Council on Medical Services' report on automobile related injuries, the Council recommended the FMA endorse the Mandatory Seat Belt Bill.
13. **Massage Practice Act Bill:** The Council recommended that the FMA oppose this bill based on the fact that colonic irrigation should not be performed by non-medical personnel.
14. **Blue Ball Rat Poison:** The Council recommended that the FMA request the Commissioner of Agriculture to put more stringent regulations on the dissemination of Blue Ball Rat Poison which has caused several children to experience severe medical problems as the result of ingestion of this rodenticide.
15. **Licensing of Dieticians Bill:** The Council recommended that the FMA oppose the Licensing of Dieticians Bill.
16. **Spinal Health Month:** The Council recommended that the FMA correspond with the Governor concerning the proclamation declaring October 1984 as Spinal Health Month, in order to fully disclose some of the misleading statements made about chiropractic medicine in the proclamation.
17. **Psychiatric Benefits:** The Council recommended that the FMA require the FMIT to provide the Council with detailed hard claim data, including comparative data and actuarial projections regarding the cutting of psychiatric benefits instituted in 1982. The Council felt available data should be studied in order to properly address this issue.

Council on Specialty Medicine
Criteria for Specialty Group Recognition

1. That the organization's purpose and need not be covered by an already existing organization and must be a specialty or subspecialty recognized by the Council on Specialty Medicine;
2. That there is a sufficient number of physicians seeking the privileges of society;
3. That the organization must have held at least two annual meetings at which a quorum was present prior to the time of application, and must continue to have an annual meeting each subsequent year of recognition;
4. That a constitution and/or bylaws state its organizational structure, purpose and aims;
5. That the membership will abide by the "Principles of Medical Ethics" of the FMA and AMA;
6. That the organization provide continuing medical education to its members;
7. That the organization have statewide representation;
8. That 100% of the active eligible members shall be members of the FMA (a 10% variation may be allowed by the Board of Governors);
9. That the attendance record of the Council representative will be considered at the time of recognition;
10. That specialty groups be required to participate in the Florida Medical Association Annual Meeting at least once every three years;
11. That participation in joint scientific sections at the FMA Annual Meeting qualify the participating specialty groups as meeting this criteria;
12. That the Council on Specialty Medicine monitor the FMA-recognized specialty groups to insure this criteria is being met; and
13. That FMA specialty groups are still required to meet the continuing medical education requirements in recognition.

Report A
of the
Board of Governors

The Reference Committee recognized Daniel B. Nunn, M.D., Editor, *The Journal of the Florida Medical Association, Inc.*, from May of 1980 to May of 1985, for his superb contributions of the scientific publications and medical information available to the membership during his tenure.

Report A of the Board of Governors was adopted as presented except for those portions referred to other Reference Committees, and that special attention be given to the Prescription Abuse Data Synthesis (PADS) Program with information being disseminated to the membership concerning this program.

Recommendation No. G-1 was adopted as presented.

Recommendation No. G-2 was adopted as presented.

Report A
of the
Board of Governors
Frank C. Coleman, M.D.

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

The Annual Report of the major activities of the Council on Scientific Activities is included in this section of the Delegates' Handbook. The Board of Governors has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

1985 Annual Meeting: The Board established the format for the 1985 Annual Meeting, May 1-5 at the Diplomat Hotel in Hollywood, Florida, and approved a scientific theme, "Quality Medicine in a Rapidly Changing Enviornment." The Board approved a symposium on this timely subject to be held on Thursday, May 2 from 4:00 p.m.-5:00 p.m. and requested that no other activities be scheduled at that time. It is expected that some 22 specialty societies will participate in the scientific sections and FMA members can earn up to 20 hours AMA Category I continuing medical education credit.

PADS Symposium: The Board of Governors approved FMA co-sponsorship of the PADS Symposium by the University of South Florida and the AMA.

CME Reporting: The Board requested the Council to reexamine the process of CME reporting and the need to involve county medical societies.

CME Research Project: The Board approved FMA support and participation in a nationwide study of the status of continuing medical education being conducted by The Society of Medical College Directors of CME.

FMA Journal Editor: The Board expressed its highest commendations and appreciation to Daniel B. Nunn, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, and Chairman of the Committee on Scientific Publications for his superb contributions and efforts as Editor of *The Journal* for the past five years.

The Board approved the President-Elect's selection of Remigio G. Lacsamana, M.D., Daytona, as Dr. Nunn's successor to serve as Editor of *The Journal* for the Association year 1985-86.

COUNCIL ON SPECIALTY MEDICINE

The Annual Report of the major activities of the Council on Specialty Medicine is included in this section of the Delegates Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Specialty Society Legislative Programs: The Board approved the recommended legislative objectives for the Florida Society of Ophthalmology and referred these to the Council on Legislation for consideration of the appropriate category of FMA support, including the defeat of any legislation that would authorize optometrists to use or prescribe legend drugs in the diagnosis or treatment of medical problems of the eye, opposition to legislation that would authorize optometrists hospital staff privileges, and opposition to any legislation that attempts to change the present law allowing medical examiners to remove corneal tissue under certain conditions.

The Board approved the recommended legislative objectives of the Florida Society of Anesthesiologists and referred these to the Council on Legislation for determination of the appropriate category of FMA support, including legislation that would ensure that certified registered nurse anesthetists be supervised by a physician or preferably be medically directed by an anesthesiologist; ensure that staff privileges are not mandated for nurse anesthetists; opposition to any legislation which would permit dentists to give anesthesia for non-dental procedures; and continue efforts to pass meaningful tort reform.

Naturopathic Practice: The Board expressed support for legislation prohibiting any further licensing of naturopathic practice.

Confidentiality of Patient Records: The Board expressed opposition to any legislation or request that would allow for the release of the confidential portion of patient medical records.

Licensing of Physicians: The Board reaffirmed the FMA's opposition to any legislation that would allow in special cases for physicians to bypass state licensing boards to practice medicine in Florida, and referred this to the Council on Legislation for appropriate action.

Specialty Group Recognition: The Board approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates for recognition by the Association: (Appendix A-1)

Florida Society of Clinical Oncologists
Florida Society of Dermatology
Florida Gastroenterologic Society
Florida Society of Neonatal-Perinatologists
Florida Society of Neurology
Florida Orthopedic Society
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society
Florida Society of General Surgeons
Florida Society of Rheumatology
Florida Society of Pathologists
Florida Endocrine Society
Florida Society of Physical Medicine and Rehabilitation

The Board authorized a 60-day grace period beginning February 23 and ending April 30, 1985 to the following specialty groups who have greater than a 10% variation in non-FMA members and who are actively seeking compliance from their members:

Florida Society of Anesthesiologists
Florida Occupational Medical Association
Council of Florida District Branches of the American Psychiatric Association

The action taken regarding these specialty societies will be included in a Supplemental Report of the Council to the House of Delegates. The Florida Association of Nuclear Physicians was placed on one year probation for not having met all the criteria for continuing recognition by the FMA.

Recognition Criteria: The Board disapproved a recommendation that FMA eliminate the requirement that specialty groups participate in the scientific section of the FMA Annual Meeting at least once every three years.

Specialty Group Representation in the House of Delegates: The Board determined that the FMA Board of Governors recommend to the House of Delegates for consideration at its next Annual Meeting that each member of the Council on Specialty Medicine or their alternate be allowed one vote in the FMA House of Delegates. (Please refer to Board Report C, [blue], Reference Committee III in the Delegates Handbook.)

Medicare Freeze: The Board endorsed the American Medical Association's action regarding the Deficit Reduction Act and Medicare freeze by asking physicians to voluntarily freeze their fees under Medicare for one year.

Terminally Ill Patients: The Board requested the FMA Judicial Council to conduct an indepth study of all existing policies of the FMA and AMA pertaining to the withdrawal or withholding of medical care for the terminally ill patient, and that a summary and any legal implications of this study be transmitted to the FMA membership.

Motorcycle Helmets: The Board expressed opposition to any legislation that would allow motorcycle operators and passengers not to wear protective head gear, and referred this action to the Council on Legislation.

Massage Practice: The Board expressed opposition to legislation that would allow licensed massage therapists to perform colonic irrigation, and referred this action to the Council on Legislation.

Rat Poison: The Board recommended to the Commissioner of Agriculture that "Blue Ball Rat Poison" and all other similarly dangerous compounds be banned or distributed in a tightly controlled manner with appropriate packaging in order to prevent children from ingesting these compounds.

Governor's Proclamation Regarding Chiropractic: The Board advised the Governor of the FMA's concern regarding the proclamation he issued on chiripractic which states, "The science of chiropractic and the doctors who practice it have contributed greatly to the better health of our citizens by providing this specialized health care."

Report G
Supplement to Report A
of the
Board of Governors

Report G, Supplement to Report A, of the Board of Governors was adopted.

Report G
Supplement of Report A
of the
Board of Governors
Frank C. Coleman, M.D.

The Board of Governors authorized a 60-day grace period beginning February 23, and ending April 30, 1985, to three specialty groups who have greater than a 10% variation in non-FMA members and who are actively seeking compliance from their members.

Since the time period has expired, the Florida Society of Anesthesiologists have met all criteria to be recognized as a member on the Council of Specialty Medicine.

Two other specialty groups did not meet the membership criteria during the 60-day grace period and, therefore, were recommended to be placed on a one year probation.

RECOMMENDATION NO. G-1

THAT CONTINUING RECOGNITION BE GRANTED TO THE FLORIDA SOCIETY OF ANESTHESIOLOGISTS WHICH HAS MET THE CRITERIA ESTABLISHED BY THE HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION.

RECOMMENDATION NO. G-2

THAT THE FOLLOWING SPECIALTY GROUPS WHO HAVE NOT MET ALL THE CRITERIA ESTABLISHED BY THE HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION BE PLACED ON A ONE-YEAR PROBATION:

Florida Occupational Medical Association
Council of Florida District Branches of the
American Psychiatric Association

RESOLUTION 85-20
Continuing Medical Education
Hillsborough County Medical Association

Resolution 85-20 was not adopted.

The Reference Committee observed that most of the testimony at the meeting by the attendees indicated that CME requirements of the FMA should continue to be enforced.

The Reference Committee expressed its appreciation to all members of the Association who appeared at their meeting to provide guidance and counsel.

Special thanks was conveyed to Richard G. Connar, M.D., who represented the AMA Delegates at the meeting of the Reference Committee. The Chairman expressed his sincere appreciation to members of the Committee: Gaston Jose Acosta-Rua, M.D.; Robert B. Peddy, M.D.; Hector R. Mendez, M.D.; Dolores A. Morgan, M.D.; Ernest C. Smith Jr., M.D.; Douglas A. Newland, M.D.; and Charles J. Kahn, M.D.(AMA Alternate). The Reference Committee also thanked FMA staff Dr. Robert C. Fore and Ms. Dawn Bouchard for their assistance in the preparation of the Report.

The motion of the Reference Committee that the Report of Reference Committee No. I, Health and Education, be adopted as amended carried.

Report of Reference Committee No. II Public Policy

Dr. Perry called the Chairman and members of Reference Committee No. II, Public Policy, to present their Report.

Dr. Luis R. Guerrero, Chairman, and his Committee came forward to present the Report of Reference Committee No. II, Public Policy.

Report of the Council on Medical Services

The motion of the Reference Committee that the Report of the Council on Medical Services be adopted as printed in the Handbook carried.

Council on Medical Services

Joseph T. Ostroski, M.D., Chairman

The creation of a sixth component committee, the Committee on Health Manpower, helped make 1984-85 an extremely active year for the Council on Medical Services. The Council met twice, September 16, 1984, and February 8, 1985, to review the work of the Committee on Aging, the Committee on Health Manpower, the Committee on Emergency Medical Services, the Committee on Public Health, the Committee on School Health and the Committee on Substance Abuse.

Recommendations of the Council and its committees have been submitted to the Board of Governors from time to time during the year, and the following is a general summary of their activities.

Committee on Aging

The Committee on Aging, ably headed this year by Clyde M. Collins, M.D., of Jacksonville, met only once, but it has been deeply involved in carrying out, in cooperation with the FMA Auxiliary, a public relations and education project concerning Florida's senior citizens.

A major element in this project has been the development, printing and distribution of "Medi-File", a wallet-size card for senior citizens. Purpose of the card is to provide a personal registry for all prescription drugs being taken by the carrier, allergies, and other medical information.

Hundreds of physicians have requested supplies of "Medi-File" for their patients, and three printings totalling 500,000 copies have been authorized to date. In addition, a Spanish language version is under consideration.

A newspaper column entitled "Health Notes for Older Adults" is being distributed on a monthly basis. So far subjects have included "Exercise", "Osteoporosis", "Drugs", and "Recipe for '85". The column is being sent to various publications targeted to senior citizens as well as to FMA's regular mailing list of newspapers and magazines.

Another major project of the Committee this year is the planning and presentation of a "Symposium on the Care of the Aging Patient" at the 1985 FMA Meeting. Speakers will include: John C. Beck, M.D., Director of the UCLA/USC Long-Term Care Gerontology Center, Los Angeles, California; George J. Caranasos, M.D., University of Florida College of Medicine, Gainesville; Eric Pfeiffer, M.D., University of South Florida College of Medicine, Tampa; and Steven Sevush, M.D., University of Miami School of Medicine, Miami.

Committee on Emergency Medical Services

The Committee on Emergency Medical Services, competently directed by Daniel E. Lucas, M.D., of Stuart, has met twice this year. Its major project has been the development of effective trauma center legislation in cooperation with the Florida Office of Emergency Medical Services, the FMA Council on Legislation, and other interested groups. The EMS Committee, working with the State EMS Advisory Council, will submit legislation that will seek to establish designation, regionalization and categorization of trauma centers in Florida.

In support of this endeavor, the Committee developed and distributed during September and October an attractive media kit consisting of journal articles written by nationally known authorities on trauma and excerpts from the Florida Medical Foundation's *EMS Project Report.*

The Committee also has been interested in the expansion of the 911 emergency telephone number into areas which do not already have it, and state-of-the-art poison control centers.

In addition, the Committee has reviewed and commented upon various administrative rules covering ambulances and other aspects of emergency care proposed by the Florida Office of Emergency Medical Services.

Committee on School Health

The affairs of the Committee on School Health have been effectively administered by Bernard Kimmel, M.D., of West Palm Beach, who last November was elected to the Florida House of Representatives. At the time this report was prepared, the Committee had met three times during 1984-85 and had a fourth session planned for April in conjunction with the School Health Conference in Tampa.

Perhaps the Committee's greatest area of concern has been a 1984 amendment to Chapter 232, Florida Statutes, which is being interpreted to permit chiropractors and other limited care practitioners to perform pre-school health examinations. Appropriate recommendations in this area have been addressed to the Board of Governors.

As the School Health Medical Advisory Committee to the Department of Education and the Department of Health and Rehabilitative Services, the Committee has reviewed and approved: standards for clean intermittent catheterization; standards for emergency first aid procedures for insect sting reactions; contents of school bus first aid kits; and school bus driver application forms and examinations.

The Committee is in the process of developing a communicable diseases document for use by nurses, teachers and other school personnel. The document will summarize the more common communicable diseases and provide information on incubation periods, periods of communicability and recommendations as to when a diseased student should be excluded from and readmitted to school. Among other things, the document will address the sensitive areas of sexually transmitted diseases and Acquired Immune Deficiency Syndrome (AIDS). The Committee is most grateful to State Epidemiologist Jeffrey Sacks, M.D., for his help in developing this document.

In the area of substance abuse, the Committee has developed and forwarded to the Board of Governors, through this Council, appropriate recommendations concerning drug education from kindergarten through high school.

For several years the Committee has been attempting to develop a model pre-participation physical examination form, a subject that has fomented some debate in reference committees of the House of Delegates for the past two years. Instead of once again recommending universal adoption of a specific form, the Committee has cited forms in use in the Duval County School system as prototypes; developed a checklist for school systems which wish to develop their own forms; and volunteered to review any new forms developed for completeness and adequacy.

Committee on Health Manpower

Daniel Seckinger, M.D., of Miami, has been extremely effective in the first year's operation of the new Committee on Health Manpower. The Committee has met twice to tend to the many tasks assigned to it by the FMA Board of Governors.

One of the major areas attracting the Committee's attention has been the problem of foreign medical graduates, particularly American citizens who have studied at the so-called "off-shore medical schools". One of the Committee's meetings was devoted almost exclusively to this issue. The Committee has reviewed the various legislative proposals of the Florida Department of Professional Regulation to contain this problem from a licensure standpoint and has forwarded its recommendations to the Board of Governors through the Council.

The Committee has been charged with responsibility for monitoring the legislative activities of allied health groups which seek to expand their scope of practice. One such group is the pharmacists who once again are asking the Legislature to invest them with limited drug prescription privileges. In this area, too, the Committee has made recommendations.

At the present time, the Committee is assembling a list of physicians representing each FMA recognized specialty group who can be called upon to testify before legislative committees on medically related issues, including health manpower. The Committee hopes to complete this roster before the opening of the 1985 Florida Legislature.

One other major project of the Committee has been to attempt to determine areas of shortage and oversupply of the various medical and surgical specialties within Florida. The first effort to assemble this information through query to the national specialty groups corresponding to the boarded specialties was not especially successful.

Some have indicated they have made no manpower studies, and the information received from most of the others was too general to be of great use in making intrastate regional determinations. Other approaches are being made to obtain this information.

Committee on Substance Abuse

The Committee on Substance Abuse has been capably chaired by Joseph H. Deatsch, M.D., of Jacksonville. The Committee has met once, and has been active in a number of areas, including participation in the work of the Governor's Task Force on Alcohol and Drug Concerns; and the Florida Prescription Abuse Data Synthesis (PADS) project committee.

In addition, the Committee assisted with the planning of Florida's first Statewide Conference on Prescription Drug Abuse and Misuse in Tampa in October, 1984; and the Southeastern Conference on Prescription Drug Abuse, which will be conducted in Charleston, S.C., in May 1985.

In the near future, the Committee plans to begin work on a drug reeducation curriculum for physicians.

Committee on Public Health

Robert D. May, M.D., of New Port Richey, has provided able leadership to the Committee on Public Health which, at the time this report was prepared, had conducted two meetings and planned a third for March.

In order to process its heavy workload, the Committee has been organized into subcommittees on governmental regulations; legislative study; education and public relations; and environmental health and consumer protection. The bulk of the workload of these subcommittees is handled by mail or telephone.

The Committee's effectiveness also has been enhanced by the addition of an obstetrician-gynecologist and a family physician to the Committee's roster, as well as prominent academicians in public health or related disciplines from the University of Miami, the University of Florida and the University of South Florida, who have been appointed as advisory members.

The Committee on Public Health has considered and drafted recommendations on a variety of public health matters including: septic tanks in industrial parks; sexually transmitted diseases laws; permitting inland bodies of water as bathing places; fluoridation of public water supplies; Florida's primary care initiative and others.

Report B of the Board of Governors

The Reference Committee commended the Board of Governors for its outstanding performance during the year.

A motion of the Reference Committee carried to adopt Recommendation No. B-1 as amended.

Report B of the Board of Governors was adopted as amended except for those portions referred to other Reference Committees.

Recommendation No. B-2 was adopted.

Recommendation No. B-3 was adopted.

Report B of the Board of Governors

Frank C. Coleman, M.D., Chairman

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

The Annual Report on the major activities of the Council on Medical Services is included in this section of the Delegates Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or rec-



Reference Committee II (Public Policy) was chaired by Luis R. Guerrero, M.D., Palm Beach Gardens. Left to right: Peter A. Tomasello, M.D., Plantation; Charles S. Eytel, M.D., Naples; Harold G. Norman, M.D., Coral Gables; Joseph T. Ostroski, M.D., Miami; not pictured Ms. Anita Suddeth, Recorder. Standing Dr. Guerrero; Robert E. Windom, M.D., Sarasota; Wallace M. Philips Jr., M.D., Orlando; Michael R. Redmond, M.D., Pensacola; John W. Glotfelty, M.D., Lakeland.

ommendations to the House regarding each of the items addressed by the Council.

National Conference on Long Term Care For the Elderly: The Board approved FMA endorsement and participation in a national conference on implementing community based long term care for the elderly, to be presented in Miami Jewish Home and Hospital for the Aged and the Area Agency on Aging of Dade and Monroe County. The Board requested that the Dade County Medical Association, the Monroe County Medical Society and their respective auxiliaries be consulted in the planning process.

Symposium on Care of the Elderly: The Board approved the concept of a "Symposium on Care for the Elderly Patient" to be held in conjunction with the 1985 FMA Annual Meeting.

Committee on Health Manpower: The Board adopted as goals for the Committee on Health Manpower:

Identify those allied health groups that anticipate expanded activity through legislation or regulatory means;

If possible, identify the goals of each allied health group;

Develop an adequate data base for use by FMA, the staff and communicating with allied health groups;

Develop a data base on physician manpower in Florida with identification of areas of shortages and what steps are being taken to correct these shortages;

Develop a roster of expert witnesses who will be available upon short notice to represent FMA at legislative hearings;

Cooperate with other agencies and groups to resolve problems with foreign trained health professionals.

"Medi-File" Card: The Board approved sending a copy of the "Medi-File" card to each FMA member with a letter explaining its purpose and use. The "Medi-File" card is a public relations and education program for the elderly developed in cooperation with the FMA Auxiliary to provide an easily accessible way of recording information on prescription drugs being taken by patients over 65 years of age. The Board also authorized that the "Medi-File" card be published in Spanish.

Primary Care Program Initiative: The Board urged the Department of Health and Rehabilitative Services to continue its flexible policy in the evaluation of grants under the primary care program initiative (Laws of Florida 84-35) and further, of the importance of involving the private practice community and educational institutions in the development of primary care program initiative.

EMS Legislation: The Board approved and referred to the Council on Legislation for determination of the appropriate level of FMA support the recommendation that FMA seek the enactment of EMS legislation that will establish the concept of regional designated trauma centers in Florida, create an up-to-date system of poison control centers and encourage statewide implementation of the 911 emergency telephone system.

Health Manpower Shortage Areas: The Board reviewed proposed procedures for evaluating designated health manpower shortage areas that would put FMA in a better position to respond within the 30 day period allowed by the Department of Health & Human Services.

RECOMMENDATION NO. B-1

HEALTH MANPOWER SHORTAGES: THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING PROCEDURE FOR REVIEW AND COMMENTS ON PROPOSED DESIGNATIONS OF HEALTH MANPOWER SHORTAGE AREAS IN FLORIDA REFERRED TO THE FMA BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

1. **THE REQUEST FOR COMMENT, ALONG WITH THE ORIGINAL APPLICATION AND OTHER SUPPORTING PAPERS SUPPLIED BY HHS, UPON RECEIPT BY THE FMA WILL BE FORWARDED IMMEDIATELY TO THE SECRETARY OF THE APPROPRIATE COUNTY MEDICAL SOCIETY.**

2. **THE MATERIAL WILL BE ACCOMPANIED BY A LETTER FROM THE COMMITTEE ON HEALTH MANPOWER REQUESTING THE COUNTY MEDICAL SOCIETY TO RESPOND DIRECTLY TO FLORIDA MEDICAL ASSOCIATION WITH A COPY SENT TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.**

3. **IN THE CASE OF PROPOSED DESIGNATIONS INVOLVING DENTAL SERVICES, THE FLORIDA DENTAL ASSOCIATION WILL BE PROVIDED WITH COPIES OF ALL CORRESPONDENCE SIMULTANEOUSLY.**

4. **THE FMA HEADQUARTERS WILL MAINTAIN A FILE ON ALL PROPOSED DESIGNATIONS, AND THE ESSENTIAL COMPONENTS OF ALL CASES WILL BE REPORTED FROM TIME TO TIME TO THE COMMITTEE ON HEALTH MANPOWER AND THE COUNCIL ON MEDICAL SERVICES.**

School Entry Health Examinations: The Board directed that the Department of Health and Rehabilitative Services be advised that the FMA strongly objects to the interpretation of Section 232.0315, Florida Statutes, which authorizes chiropractors to perform school entry health examinations, and supported the policy that all such examinations be completed by a licensed Doctor of Medicine or Doctor of Osteopathy.

Fingerprinting of Children: The Board endorsed programs of voluntary fingerprinting of children as an aid in identifying missing persons.

Child Abuse: The Board encouraged the FMA membership to participate in promoting recognition of, and education concerning, child abuse in both family and institutional settings.

Methadone Programs: The Board urged the Florida Department of Health and Rehabilitative Services to employ a knowledgeable and qualified individual to monitor compliance with, and exceptions to, the 1984 regulations governing methadone treatment programs.

Prescription Abuse Date Synthesis Project (PADS): The Board recommended to the Department of Professional Regulation that it look into the possibility of deputizing members of the triage committee provided for under the FMA's policy on drug diversion identification and intervention.

Legislation of Heroin: The Board expressed strong opposition to the legalization of heroin as proposed in HB 5290 for use in controlling pain for terminal patients.

Dupont Pharmaceuticals: The Board commended Dupont Pharmaceuticals for its current campaign to alert pharmacists to the potential for drug diversion through fraudulent prescriptions.

Physician Responsibility Re: Prescription Drugs: The Board requested that FMA members be reminded of their responsibility to cooperate fully with pharmacists in ascertaining the legitimacy of individual prescriptions whether ordered by verbal or written means, and to verify these prescriptions with the pharmacist personally whenever possible.

Drug Diversion Education: The Board authorized the Council on Scientific Activities to assist the Committee on Substance Abuse in forming a work group of physicians that would identify needs, set goals and plan curricula for the education and reeducation of physicians in the areas of prescription drugs and prescription drug diversion.

National Commission on Correctional Health Care: The Board endorsed the program of the National Commission on Correctional Health Care for accreditation research and training in correctional health care. The Commission, which includes representatives of several national medical and health organizations including the AMA, plans to continue the jail health care accreditation program begun by the AMA several years ago.

Environmental Hazards: The Board expressed support for legislation to expand Chapter 381, Florida Statutes, to include reporting of diseases (Morbidity and Mortality) related to environmental hazards.

Occupational Disease: The Board approved the FMA support for institution of an occupational health program at the state level within the Health Program Office to assess the magnitude of occupational disease in Florida.

Hepatitis B: The Board supported the development of a policy on management of Hepatitis B in state institutions and among clients and employees of the Florida Department of Health and Rehabilitative Services to be transmitted to the Health Program Office of HRS.

Public Health - Public Relations Program: The Board approved an FMA public health education program directed at the general public and the medical profession; and further, that this program be accomplished through the production and distribution of radio and television public service announcements addressing such themes as driving and drinking, use of drugs, automobile safety belts and smoking.

Septic Tanks in Industrial Parks: The Board urged the Health Program Office to insure that septic tanks in industrial parks will not be used for disposal of toxic or hazardous chemicals.

Substance Abuse and Chemical Education K through 12:

RECOMMENDATION NO. B-2

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING FMA POSITION WITH REGARD TO SUBSTANCE AND CHEMICAL ABUSE EDUCATION IN FLORIDA SCHOOLS UP TO GRADE 12:

1. **URGE THE LEGISLATURE TO PLACE MORE EMPHASIS ON THE TEACHING OF HEALTH EDUCATION, INCLUDING SUBSTANCE ABUSE, IN THE ELEMENTARY, MIDDLE SCHOOLS, AND HIGH SCHOOLS.**
2. **RECOMMEND TO THE LEGISLATURE THAT SECTION 230.2319, FLORIDA STATUTES, KNOWN AS FLORIDA PROGRESS IN MIDDLE CHILDHOOD EDUCATION PROGRAM (PRIME) BE AMENDED TO MANDATE THE TEACHING OF HEALTH EDUCATION, INCLUDING SUBSTANCE ABUSE, STRESS MANAGEMENT AND EMOTIONAL HEALTH IN GRADES 4 THROUGH 5 THROUGH 8. AS IT CURRENTLY EXISTS, THIS LAW PROVIDES ONLY LIMITED HEALTH EDUCATION IN MIDDLE GRADES.**
3. **RECOMMEND TO THE LEGISLATURE THAT TEACHER CERTIFICATION REQUIREMENTS INCLUDE AN IN-DEPTH COURSE IN HEALTH EDUCATION AND SUBSTANCE ABUSE. THE MAIN FOCUS OF THE CURRICULUM SHOULD BE ON PREVENTION, BUT IT SHOULD ALSO INCLUDE IDENTIFICATION OF THE SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE AND THE PROCEDURES FOR INTERVENTION WITH STUDENTS AND THEIR FAMILIES.**
4. **COMMENDED THE LEGISLATURE FOR PASSAGE OF THE REQUIRED ONE SEMESTER LIFE MANAGEMENT SKILLS COURSE TO BE TAKEN IN THE 9TH OR 10TH GRADE. THE LEGISLATURE SHOULD BE ALERTED TO THE FACT THAT THIS IS THE LAST TIME STUDENTS WILL BE INVOLVED IN HEALTH EDUCATION AND SUBSTANCE ABUSE COURSES. IT WOULD BE OF VALUE TO STUDENTS IF AN ADDITIONAL COURSE AT THE 11TH AND 12TH GRADE LEVEL WOULD BE REQUIRED SINCE THE QUALITY OF LIFE IS SO DEPENDENT ON AN INDIVIDUAL'S HEALTH.**
5. **RECOMMEND TO THE LEGISLATURE CONTINUED CATEGORICAL FUNDING FOR COMPREHENSIVE HEALTH EDUCATION.**

Hand Washing Facilities in the Schools: The Board recommended to the Florida Department of Education that proper hand washing by school students is one act of personal hygiene that can reduce the spread of many communicable diseases in the school setting, and further, urged the Department to adopt requirements for new school construction that will assure the installation of adequate numbers of conveniently located sinks for hand washing.

Isolete Cell Antibody - Diabetes Study: The Board reaffirmed FMA endorsement of research being conducted at the University of Florida by Knoll K. Maclaren, M.D., and others, entitled "Isolete Cell and Autoantibodies and Natural History of IDD."

Witnesses: The Board determined that each FMA recognized specialty groups be requested through the Council on Specialty Medicine to nominate five (5) of its members who would be willing to testify as necessary on behalf of FMA before legislative committees on all health related issues, including health manpower.

Florida High School Activities Form: The Board approved the recommendation that health history and interval health history and physical examination forms such as those used in Duval County public schools be used as a prototype for health examination forms in other counties; and, further, that if the County School Boards wish to develop their own health examination form, the Florida Medical Association School Health Medical Advisory Committee would volunteer to review them for adequacy and completeness in accordance with guidelines developed by the Committee. (To be included in the Delegates' Notebook.)

Participating Physical: The House of Delegates at its 1984 meeting, approved Recommendation No. B-3 of the Council on Medical Services regarding preparticipation physicals:

> That the House of Delegates recommend to the Florida High School Activities Association that preparticipation physicals be required once at the entry of junior high school level and once at the entry of high school level with annual updated histories on a yearly basis.

RECOMMENDATION NO. B-3

THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING AMENDED POLICY OF THE FMA REGARDING PREPARTICIPATION PHYSICALS:

"THAT THE HOUSE OF DELEGATES RECOMMEND TO THE FLORIDA HIGH SCHOOL ACTIVITIES COMMISSION THAT PREPARTICIPATION PHYSICALS BE REQUIRED ONCE AT THE ENTRY OF JUNIOR HIGH SCHOOL LEVEL AND ONCE AT THE ENTRY OF HIGH SCHOOL LEVEL WITH ANNUAL UP-DATED HISTORIES THEREAFTER, AND REPEAT PHYSICALS AS INDICATED.

Prison Medical Services In Florida: The Board authorized the FMA, in conjunction with the Florida Department of Health and Rehabilitative Services (HRS), propose to the Florida Legislature that funds be provided, through HRS, to the Florida Medical Foundation for:

1. Evaluation of the current jail medical care system in Florida;
2. Formulation of recommendations for meeting AMA recognized standards; and
3. Provision of expertise and in impetus for localities to implement accredited programming.

Fluoridation of Public Water Supplies: The Board reiterated the FMA's support for fluoridation of public water supplies in Florida.

Samuel Rowley, M.D. - Retirement: The Board took official notice of the impending retirement of Samuel Rowley, M.D., from the position of Public Health Director of Duval County. The Board, in behalf of FMA , wishes to commend Dr. Rowley for the many contributions he has made to public health in that position and as a member of the FMA Committee on Public Health.

RESOLUTION 85-11
Organ Harvesting
Dade County Medical Association

The motion for the Reference Committee to amend the "Resolved" portion of the Resolution to read as follows:

"RESOLVED, That the Florida Medical Asso ciation, through its membership, does endorse orga donation as an appropriate and meaningful ex perience for the recipients and the grieving families and be it further

RESOLVED, That FMA members should en courage hospital involvement in the maintenance o the potential organ donor as the ultimate life-savin opportunity for those who suffer from end-stag organ failure; and be it further

RESOLVED, That the Florida Medical Associa tion encourage its members to assist the transplan programs in their efforts to procure donated organ for transplantation and thus become integra members of the "transplant team" in its life-savin efforts; and be it further

RESOLVED, That the FMA Board of Governor evaluate the need for and, if appropriate, pursue pro per legislation to implement this program."

Resolution 85-11 was adopted as amended.

RESOLUTION 85-11
Organ Harvesting

"RESOLVED, That the Florida Medical Association, throug its membership, does endorse organ donation as an appropria and meaningful experience for the recipients and the grievi families; and be it further

RESOLVED, That FMA members should encourage hospit involvement in the maintenance of the potential organ donor the ultimate life-saving opportunity for those who suffer fro end-stage organ failure; and be it further

RESOLVED, That the Florida Medical Association encourag its members to assist the transplant programs in their efforts procure donated organs for transplantation and thus become i tegral members of the "transplant team" in its life-saving effort and be it further

RESOLVED, That the FMA Board of Governors evaluate th need for and, if appropriate, pursue proper legislation to impl ment this program."

RESOLUTION 85-17
All Terraine Vehicle (ATV) Injuries
Collier County Medical Society

The motion of the Reference Committee tha Resolution 85-17 be adopted and referred to th Board of Governors for determination of fiscal im pact with the editorial change of deleting "thre wheel" from the first line was carried.

RESOLUTION 85-17

All Terraine Vehicle (ATV) Injuries

(Adopted — Referred to Board of Governors)

Whereas, All terraine vehicles (ATVs) are recreational mot vehicles which are becoming more popular nationally and Florida particularly (260% since 1982)*; and

Whereas, The number of emergency room ATV related injuries has increased 800% and related deaths 300%*; and

Whereas, Almost three-fourths of the victims were between the ages of five and twenty-four*; and

Whereas, The main problems seen in the majority of ATV accidents are instability and difficulty of control*; and

Whereas, The U.S. Consumer Product Safety Commission recommends active state and local education programs concerning the dangers of these recreational vehicles; and

Whereas, Public health and safety education is a proper function of organized medicine; therefore be it

RESOLVED, That the FMA undertake a strong campaign to educate the public regarding the serious dangers of all terraine vehicles (ATVs) through the electronic and printed media as well as programs in the schools.

*U.S. Government Memorandum; Update of Actions on All Terraine Vehicles, February 20, 1985. U.S. Consumer Product Safety Commission.

RESOLUTION 85-23
Pre-School Physical Examinations
Duval County Medical Society

Resolution 85-23 was adopted.

RESOLUTION 85-23
Pre-School Physical Examinations

RESOLVED, That the Florida Medical Association opposes the performance of pre-school health examinations by chiropractors and other limited care practitioners as being contrary to the best interests of the school children of Florida; and be it further

RESOLVED, That the Florida Medical Association believes that the pre-school examination is of such importance to the health and well-being of children that only an examination and certification performed and signed by a qualified Doctor of Medicine or Doctor of Osteopathy should be accepted by local boards of education; and be it further

RESOLVED, That the Florida Medical Association work with its county medical societies and recognized specialty groups, the Florida Osteopathic Medical Association, state government agencies and local school boards to develop programs that will make a pre-school examination by a qualified practitioner available to every school child; and be it further

RESOLVED, That the Florida Medical Association adopt as part of its legislative program further amendment to Section 232.0315(1), Florida Statutes, to specify that local school boards may accept health certifications signed only by physicians licensed or as defined in Chapter 458 and Chapter 459, Florida Statutes.

The Reference Committee expressed its appreciation to all members of the Association who appeared at their meeting to provide guidance and counsel, and to Dr. Joseph T. Ostroski, Chairman of the Council on Medical Services.

Special thanks were conveyed to Robert E. Windom, M.D., and Joseph T. Ostroski, M.D., the AMA Delegates at the meeting of this Reference Committee. The Chairman expressed his sincere appreciation to members of the Committee: Doctors Michael R. Redmond, Charles S. Eytel, Wallace M. Philips Jr., Harold G. Norman, John W. Glotfelty and Paul A. Flaten.

The Reference Committee thanked FMA staff, Mr. Edward D. Hagan, Ms. Anita Suddeth and Mr. Don Weidner, Associate General Counsel, for their assistance in the preparation of this Report.

The motion of the Reference Committee that the report of Reference Committee No. II, Public Policy, be adopted as amended carried.

EMERGENCY RESOLUTION
Public Health Committee and the
Preventive Medicine Society

A motion from the floor carried to adopt as amended an Emergency Resolution as presented by Dr. Joseph T. Ostroski, Dade County.

EMERGENCY RESOLUTION

Whereas, The basic science of public health is epidemiology; and

Whereas, a basic function of public health action programming is communicable disease control; and

Whereas, epidemiology and communicable disease control has been and continues to be among the most important aspects of government action in public health; and

Whereas, the State Department of Health and Rehabilitative Services does not have an established position for the provision of epidemiologic work in Florida; and

Whereas, the Department of Health and Rehabilitative Services has looked to the Federal Government for assignment to Florida of epidemiologists for many years; and

Whereas, the Florida Society for Preventive Medicine, the specialty organization for public health of the Florida Medical Association, emphasizes the importance of a state epidemiologist

Whereas, the current assignee is leaving in June and no new assignee will be designated because of the absence of an established postition; therefore be it

RESOLVED, That the Florida Medical Association request and urge the Governor, the President of the Senate, the Speaker of the House and the Secretary of the Department of HRS to immediately establish and budget for a position of state epidemiologist and that recruitment for a qualified physician-epidemiologist licensed in the State of Florida be initiated immediately so that protection of the public's health against epidemic disease may be assured.

Report of Reference Committee No. III Finance and Administration

Dr. Perry called the Chairman and members of Reference Committee No. III, Finance and Administration, to present their Report.

Dr. Margaret C.S. Skinner, Chairman, and her Committee came forward to present the report of Reference Committee No. III, Finance and Administration.

Remarks of the Speaker of The House

Dr. Skinner expressed her Committee's wish to commend Dr. Perry for the clear and precise rules under which the House of Delegates acts and for Dr. Perry's summary given at the beginning of the Meeting.

The remarks of the Speaker presented at the First House of Delegates were filed. (See page 595, First House of Delegates.)

President's Address

Dr. Skinner expressed her Committee's wish to commend Dr. Coleman for his outstanding leadership on behalf of the members of the Association for the past year.

The President's Address presented at the First Meeting of the House of Delegates was filed. (See President's Address, page 585.)

Report of the Committee on Membership Development

The Report of the Committee on Membership Development was adopted as presented.

Committee on Membership Development

Charles K. Donegan, M.D., Chairman

The many and various challenges confronted by the FMA in the past year have emphasized the importance of an effective membership development program within the Association. In the third year of its existence, the Committee on Membership Development met three times to plan membership recruitment programs, as well as membership retention strategies.

At the end of 1984, FMA membership totaled 14,598, an increase of 121 over the comparable figure for 1983. The 14,598 included 12,854 dues paying members, of which 11,726 and 1,128 were in the active and associate member categories, respectively. There were 1,744 physicians in the dues exempt categories.

Florida's AMA member category increased from 10,471 on December 31, 1983 to 10,706 at the end of 1984, which was sufficient for FMA to retain all 11 of its seats in the AMA House of Delegates but 294 short of the number required to gain an additional seat.

Over the past year, the Committee on Membership Development has expanded its work into new areas. A summary of the Committee's more significant activities appears below:

1. **Women Physicians:** Women physicians constitute a significant target for membership development activities. As part of its program for this group, the Committee sponsored a half-day "Leadership Skills Seminar for Women Physicians" during the FMA Leadership Conference in Tampa in February. Approximately 80 women physicians attended. Special membership recruitment letters will be addressed to those non-member women physicians who attended the seminar as well as those who were invited but did not attend.

 The Committee has recommended to the Executive Committee and Board of Governors that a similar program be sponsored at the 1986 FMA Leadership Conference and that it be expanded to a full day.
2. **Membership Retention:** The Board of Governors has directed the Committee on Membership Development to work in the field of membership retention as well as recruitment. The Committee is of the opinion that the retention aspect of membership development can be most effectively addressed at the local level, particularly in the hospital medical staff setting. Accordingly, your Committee has recommended to the FMA Board of Governors that each FMA component medical society be urged to create a membership development committee and that it consider appointing to this committee a representative from each local hospital medical staff, as well as women physicians, resident physicians and medical students, where possible.
3. **Medical Students and Residents:** Upon recommendation of your Committee, the Board of Governors has voted in favor of establishing medical student and resident physician sections within the FMA. Pursuant to this action and a subsequent request from the FMA Committee on Bylaws, the Committee on Membership Development has drafted amendments to the FMA Bylaws that would create a Council on Medical Student Affairs and a Council on Resident Physician Affairs and submitted them to the Bylaws Committee for further consideration. These councils would provide a forum for the expression of resident physician and medical student opinion and also provide a channel for their input into FMA policy-making.
4. **"Invitation to Join" Program:** For the second consecutive year, the Committee on Membership Development is participating in the AMA's "Invitation to Join" membership recruitment program. Under this program, two mailings—one in De-

cember and one in March—were sent to all Florida physicians and resident physicians who, according to AMA records, are not members of either the AMA or the FMA. The first mailing garnered 169 requests for additional information about joining organized medicine.

FMA Speakers' Bureau

The Report of the FMA Speaker's Bureau was adopted as presented.

FMA Speakers' Bureau
Edward R. Annis, M.D., Chairman

Summary of Activities for Year

There are no regularly scheduled or structured meetings for the Speakers' Bureau in that all elected officers, members of the Board of Governors and committee appointees are automatically participants as they reflect official policies and contribute toward the dissemination of information to members of the profession as well as to the public at large. Leading the list of active contributors during the past year has been President Frank Coleman, M.D., with press, radio and television presentations, supplemented by direct meetings with the Governor, leaders of the House and Senate, and responsible business leaders across the state.

Though the problem of professional liability has assumed high priority, the publicly and professionally recognized importance of health cost escalations has received ongoing emphasis. Regulations emanating from Washington and Tallahassee, together with many proposed for future implementation, have demanded ever-increasing activity on the part of all spokespersons for Florida medicine.

Leadership at the county medical society level reflects consistent and continuing expansion of all efforts to educate its members as well as the public on matters vital to preserving access, availability and quality medicine during a time when business and community leaders are concentrating primarily on cost. These actions at the county society level will prove to be most effective, as only an enlightened and motivated public can supply the necessary forces to modify and moderate those determined to limit costs, often at the expense of quality and availability.

Judicial Council

The Reference Committee extended a special commendation to Dr. Joseph H. Davis, Chairman, and to the members of the Judicial Council for their untiring efforts in performing the numerous activities of the Judicial Council during the past year.

The Report of the Judicial Council was adopted as presented.

Judicial Council
Joseph H. Davis, Chairman

The 1985 Annual Report of the Judicial Council will summarize the Council activities since the May 1984 Annual Meeting of the Florida Medical Association. Council duties are defined in Paragraph 8, Section 3 of the Bylaws. The Judicial Council investigates Association activities which pertain to medical ethics, dissension and disputes, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Council reviews and recommends charters for county medical societies. The Council also is the interpretive body for the Association Bylaws. A component county medical society is the basic unit for discipline of its members. Any member subject to such action has a right of appeal to the Judicial Council. The Council may be required to review component county medical societies in respect to their adherence to binding policies adopted by the House of Delegates of the Association.

Since the last Annual Meeting of the Association, the Council has convened on the following occasions: May 2, 1984, September 22, 1984 and March 23, 1985. The current membership of the Council is as follows: Joseph H. Davis, M.D., Chairman, of Miami; O. Frank Agee, M.D., of Gainesville; Robert J. Brennan, M.D., of Ft. Lauderdale; Maurice H. Laszlo, M.D., of North Miami Beach; and Kenneth C. Kiehl, M.D., of Sarasota. The Council has been staffed by Mr. Donald W. Weidner, FMA Associate General Counsel.

The Council's activities are summarized under the following headings:

Grievances

During the last year, the Council has continued to review referred grievances. It is apparent that some procedural improvements are needed.

The procedures for process of these grievances were last considered by the House of Delegates in 1972. Because of the length of time since that consideration, the Council recommended to the Board of Governors, and the Board adopted a motion that the procedures be resubmitted to the House of Delegates for reaffirmation.

In view of the current professional liability crisis, a legislative and news media spotlight has focused upon the way organized medicine fulfills its responsibilities in handling grievances.

The following paragraph is taken from the Judicial Council's Procedures for Investigation and Resolution of Grievances and is even more important today than it was in 1972.

> "It should be kept in mind that for many people who have occasion to file complaints against physicians, the county medical society grievance committee is their only formal contact with organized medicine. With medicine under attack for allegedly not policing its own ranks, it is particularly important that each individual patient be accorded all respect, courtesy and fairness possible by the Grievance Committee and its individual members. Care should be taken that the Grievance Committee's actions do not give rise to charges of 'whitewash', prejudice or inaction."

Often we find that county grievance committees or their staffs, upon receipt of a written complaint, contact only the physician involved. On the basis of the physician's response they then make a decision with no direct contact with the patient. Such a procedure gives rise to a justified impression that the committee did not care about hearing the patient's side of the issue. In every case it is important that the patient be contacted by the county committee and given an opportunity to provide any additional information not contained in his or her complaint. The patient should also be contacted after the physician has responded, should be advised of the physician's response, and should be given an opportunity to comment. The contact with the patient should be by a county committee member. Only in this way can the county grievance committee ensure that most patients will feel that they have been fairly treated.

Within the past year we have seen a significant increase in the number of grievances referred to the Council. At the time of the Annual Meeting last year we had 13 open cases. Today we have 35 open cases and have closed out another 40 cases. Additionally, we received a significant number of cases that were not within



Reference Committee III (Finance and Administration) was chaired by Margaret C.S. Skinner, M.D., Miami. Left to right: T. Byron Thames, M.D., Orlando; Glenn S. Hooper, M.D., Tampa; James T. Cook III, M.D., Panama City; Ms. Linda Flowers, Recorder; Dr. Skinner; Virgil A. Ponzoli Jr., M.D., Naples; John C. Moore, M.D., Lakeland; Robert H. Hux, M.D., Leesburg.

the jurisdiction of the Council either because the physician involved was not an FMA member or a Doctor of Medicine.

The Council also recommended to the Board of Governors that a new bylaw be adopted to provide for automatic suspension or revocation of membership if a member's license to practice medicine is suspended or revoked. When the State Board of Medical Examiners suspends or revokes a physician's license, it is often six months later before the county society or FMA grievance committee can take action against the member. Such a delay is construed by our critics as indifference to our societal obligations.

The Council is in the active process of preparing recommendations in regard to allegations of physician incompetence as it relates to the current malpractice crisis.

Review of County Medical Society Revisions to Charter and Bylaws

During the past year, the Council continued to review bylaw amendments of county medical societies to assure that such amendments are not in conflict with the Bylaws of the Florida Medical Association. County medical societies are urged to submit proposed changes in charters and bylaws to the Judicial Council in a timely manner for such review.

During the past year, the House of Delegates adopted a recommendation of the Judicial Council to create the Bradford County Medical Society and denied creation of a proposed St. Johns County Medical Society.

Florida Medical Association Policy Statement RE: Advertising (1979)

During the past year, the Council amended the endorsed specialty listing section of the Florida Medical Association Policy Statement on Advertising to include the following new approved listings:

Ophthalmology - Pediatric
Hypnosis

Members desirous of a new telephone listing should review the approved specialty code listing found within the American Medical Association Directory of Physicians. The Council considers the following as guidelines when reviewing such requests:

a) the listing serves a public need;
b) it is not redundant with another listing;
c) it is a genuine aspect of the practice of medicine;
d) it has board certified recognition;
e) it describes what the physician does.

The following is the current listing of endorsed specialty headings for yellow page advertising:

1. Aerospace Medicine
2. Allergy & Immunology
3. Allergy & Immunology - Pediatric
4. Anatomic Clinical Pathology
5. Anatomic Pathology
6. Anesthesiology
7. Blood Banking
8. Cardiovascular Disease
9. Child Neurology
10. Child Psychiatry
11. Clinical Pathology
12. Chemical Pathology
13. Colon and Rectal Surgery
14. Dermatology
15. Dermatopathology
16. Diagnostic Radiological Physics
17. Diagnostic Radiology
18. Endocrinology & Metabolism
19. Emergency Medicine
20. Family Practice
21. Forensic Pathology
22. Gastroenterology
23. General Preventive Medicine
24. Genetic Medicine
25. Gynecologic Oncology
26. General Practice
27. Hand Surgery
28. Hematology
29. Hypnosis
30. Infectious Disease
31. Internal Medicine
32. Maternal & Fetal Medicine
33. Medical Microbiology
34. Medical Nuclear Physics

35. Medical Oncology
36. Neonatal-Perinatal Medicine
37. Nephrology
38. Neurological Surgery
39. Neurology
40. Neuropathology
41. Nuclear Medicine
42. Nuclear Radiology
43. Obstetrics & Gynecology
44. Occupational Medicine
45. Ophthalmology
46. Ophthalmology - Pediatric
47. Oral & Maxillofacial Surgery
48. Orthopedic Surgery
49. Otolaryngology - Head & Neck Surgery
50. Pathology
51. Pediatrics
52. Pediatric Cardiology
53. Pediatric Endocrinology
54. Pediatric Hematology - Oncology
55. Pediatric Nephrology
56. Pediatric Surgery
57. Physical Medicine & Rehabilitation
58. Plastic Surgery
59. Psychiatry
60. Psychiatry & Neurology
61. Public Health
62. Pulmonary Disease
63. Radiologic Physics
64. Radioisotopic Pathology
65. Radiology
66. Reproductive Endocrinology
67. Rheumatology
68. Surgery
69. Therapeutic Radiological Physics
70. Therapeutic Radiology
71. Thoracic Surgery
72. Urology
73. Vascular Surgery

Supplemental Report
Judicial Council

The Supplemental Report of the Judicial Council was referred to the Board of Governors and the Board was asked to report to the House with recommendations regarding the items dealing with disciplinary actions and mechanisms for restructuring state and county grievance procedures as outlined in this report.

Supplemental Report
Judicial Council
Joseph H. Davis, M.D., Chairman

It is recognized that incompetency to practice medicine may occur as doctors are human and are subject to the same psychological problems as other people. However, there exists a stringent screening process which is designed to limit to the greatest possible extent incompetency or dishonesty in physicians. This includes: the selection process for schooling; training; certification; licensure; staff privileges; peer review; and, membership in medical societies and oversight by governmental bodies. These processes assure that incompetency and dishonesty should be minimal. Many physicians are, however, partially lost to supervision because they are not members of the Florida Medical Association or their county society.

While organized medicine believes that the number of licensed physicians who are incompetent is very small and that the role of incompetency in the genesis of malpractice suits is also low, we also recognize that organized medicine has an affirmative duty to do everything possible to find and remove from practice or limit the practice of any physician who is incompetent or inadequate. This duty is a legal responsibility, but more important, is part of the Hippocratic oath — we must put the well being of the patients first.

Critics of organized medicine discussing the malpractice crisis make highly publicized claims that:

a. The "bad doctor" is the root cause of malpractice lawsuits.
b. Organized medicine is doing a bad job in protecting the public from such "bad doctors."

An unsatisfactory therapeutic result is definitely not proof that a physician was "bad" or incompetent. However, support for and against the claim that "bad doctors" comprise the substrata for malpractice claims is hampered by lack of factual data.

No system exists to apply epidemiological techniques to litigation threats, institution of proceedings, case settlements and court rulings. No system exists to evaluate the competency of expert medical witnesses for there is no peer review of courtroom medicine. When opposing viewpoints are publicized, the perception is that doctor witnesses may not be trusted.

When litigation is concluded one or both parties are dissatisfied. Such dissatisfaction becomes a further nidus of distrust.

Distorted public perceptions arise from the aforementioned sources. Organized medicine has a most difficult problem regardless of laudable intentions. Therefore, it is incumbent upon organized medicine to constantly strive to exert control of incompetency or dishonesty of doctors while likewise building public confidence that the system is trustworthy and effective.

There exists three systems to control incompetency when it does occur. Each has its strengths and weaknesses. The weakest link in the system is the lack of effective coordination between the three systems which are:

1. The Department of Professional Regulation with its Board of Medical Examiners.
2. The Florida Medical Association with its component county medical societies.
3. The Civil Justice system.

The Department of Professional Regulation with its Board of Medical Examiners has the power to license and to discipline. In recent years it has become much more effective to the point that it ranks highest in the United States in impostion of sanctions against errant physicians. (Feinstein, R.J.: "The Ethics of Professional Regulation," *N. England J.M.*, Vol. 312, No. 12, 801-804, March 21, 1985.)

Currently, the DPR receives relatively few cases, only seven percent (7%), from hospitals or medical societies and the majority of this small percentage comes from hospital referrals.

The DPR operates with paid staff strategically located in the state. It does not utilize committees of the FMA or county societies to screen complaints.

There is a real question whether the Board of Medical Examiners has sufficient investigative staff to properly fill its role. The Board is also hampered by being part of the Department of Professional Regulation and, therefore, being unable to have full control of the priorities of the investigative and legal staff since they work for the Department and not the Board.

The FMA and its component societies have grievance committees. Statewide the Judicial Council acts as the Grievance Committee but refers complaints to the county of origin. The county societies investigate. Complaints may also go directly to the county society, may be heard and never come to the attention of the FMA. If the complainant is not satisfied, there may be an appeal to the Judicial Council.

Although this system has worked reasonably well, there are problem areas. If incompetent doctors are to be controlled by organized medicine then we must review completely the entire system of grievance procedures. Certain preliminary observations are apparent:

1. Neither the FMA nor the component societies have the necessary staff to perform detailed background investigations of each complaint.
2. The voluntary committee system lends itself to needless delay in providing a timely response. This can create the perception that the incompetent physician is being tolerated or, worse yet, approved.
3. There is lack of uniformity in the approach to handling such grievances by the various county committees and county staff personnel.
4. There is no proper data collection system to permit epidemiologicl analyses of the cases throughout the state.
5. There is a lack of consultation between the DPR and the grievance committees quite possibly because the dividing line between a grievance based upon a patient's perception of the physician and a grievance with substantive question of competence is indistinct. In fact, many grievances appear to be fee disputes rather than grievances related to competency or dishonesty. Much can be obviated by improved interpersonal relationships rather than improved technical skills. Obviously, these types of grievances are best handled by organized medicine.

The Civil Justice system, in theory, would be a potential source of information for control of incompetency. However, the truly incompetent physicians are rarely sued while those in high risk specialties are more likely to be sued, not because of incompetence but because of a bad result. Likewise, the entire court system, as now operated, is devoid of good data collection capability for purposes of study of the problems.

How may the Florida Medical Association improve the systems in which incompetent or dishonest physicians come to the attention of the Board and the Association. Improvement may be sought by active participation of the FMA in:

1. Redefinition of systems to control incompetency so that each agency within each system has a clear understanding of its role and its potential for interaction with other agencies both public and private. Although the DPR operates under statutory guidelines and organized medieine operates under charter and bylaws, no formal program exists for supportive interaction. There is a representative from the Board of Medical Examiners on the Board of Governors of the FMA. Physician members of the Board of Medical Examiners belong to the FMA and respective county societies. Most have played an active role in the committee structure of organized medicine. There is need for a more formal interaction with organized medicine offering active support in the promulgation and implementation of policies of the Board of Medical Examiners (DPR). However, a physician member of organized medicine subject to DPR sanctions may look to organized medicine for support. Organized medicine is not a union which should fight for its members right or wrong. The charter of the FMA in Article II states:

> The general nature of the objects of the corporation is to promote the science and art of medicine and the betterment of public health; to unite the medical profession of Florida into one compact organization and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical education; to strive for the enactment, preservation and enforcement of just medical and public health laws; to promote friendly relationships among physicians and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies, and to carry out these objects of the corporation as a business league not organized for profit, and no part of the net earnings shall insure the benefit of any private member or individual, as an exempt corporation not for profit within section 502(c)(6), 26 U.S.C.A., Internal Revenue Code of 1954.

The tone of this article in no way indicates that organized medicine should advocate the interests of any physician whose competence or integrity is in question.

Accordingly, it is recommended that an active ongoing support liaison be established between the Board of Medical Examiners (DPR) and the FMA.

2. When integrity is not a problem, fee disputes, misconceptions between doctors and patients and problems of interpersonal relationships should be clearly separated from the grievance procedure. Mediation committees should be used for these problems. Key to this is a timely and uniform response. Currently, the system(s) are too complex with the FMA involvement being a matter of chance. A new procedure for arbitrating fee disputes should be established under the direction of the Judicial Council. The objective is to create a system which will be uniform in service to the public and which will be a perceived source of service to and for the public.
3. True grievances involving questions of competence or integrity and honesty should be handled by the Board of Medical Examiners (DPR) with tax and license fees supporting adequate staff and personnel to do the job. Organized medicine with its limited dues structure and diverse interests should not attempt to play a strong disciplinary role when the issues are those of license and the privilege of practice. There is no way that organized medicine may fund such an acitivity, and defend its sanctions when challenged, without resort to extensive increase in dues. It might be noted that the Florida Bar spends $2.2 million annually on investigations and discipline. Already, the DPR is spending considerable monies pertaining to physician discipline. It would be wasteful for organized medicine to duplicate those functions which are within the disciplinary purview of the Board of Medical Examiners (DPR). The role of organized medicine should be to forward questions of competence directly to the DPR.
4. The FMA through its legislative activities should support legislation to more clearly define and support improvements in the grievance procedures.
5. The FMA should monitor the civil and criminal court systems and be prepared to route physician questions of competence, both as litigants and expert witnesses, directly to the Board of Medical Examiners (DPR) for full investigation.
6. The FMA should carry out a strong public education program that demonstrates its support for sanctions against the incompetent or dishonest physician. Organized medicine cannot and must not permit itself to be perceived, rightly or wrongly, as indifferent to the "bad doctors" in its midst. The best method is for organized medicine to let it be known that it will encourage investigation by the Board of Medical Examiners (DPR) of any physician when competence or integrity may be in question. By competence, we mean possession of sufficient skills to enable that physician to practice at the level of ability and responsibility in keeping with the accepted standard of care. By integrity, we mean honesty, fairness, morality and decency

so that the patient is being served and managed by the physician in the same manner as the physician would want himself or a loved one to be served and dealt with if they were in the patient's situation.

Florida Medical Foundation

The Report of the Florida Medical Foundation, with the exception of the item referred to another Reference Committee, was adopted.

Florida Medical Foundation
Luis M. Perez, M.D., President

The Florida Medical Foundation Board of Directors has continued to hold their meetings in conjunction with the meetings of the Florida Medical Association Board of Governors. The Florida Medical Foundation Professional Review Organization of Florida, Inc., submitted a proposal to the Health Care Financing Administration to become the designated statewide PRO for the state of Florida. The major activities of the Foundation are summarized as follows:

1. **Peer Medical Utilization Review (PMUR):** The PMUR Committee was very active and met six times this Association Year. Over 168 physicians were reviewed including 35 appeals. The Committee has reviewed Medicare, Medicaid and Workers' Compensation cases. A moratorium implemented by the HCFA effective March 1, 1985 has put PMUR review for Medicare cases on hold until August or September, at which time it is expected that Medicare review will resume. This moratorium has been initiated due to lack of funding. (Referred to R.C. V)
2. **Committee on Impaired Physicians:** Included in the Delegates' Handbook is a report on the activities of the Committee on Impaired Physicians. This Committee continues to provide a tremendous service with outstanding results.
3. **Committee on Continuing Medical Education:** The Committee, as an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the Florida Medical Association, continues to make major contributions to continuing medical education in Florida. In 1984, the Committee reviewed and approved 65 applications from specialty groups, hospitals and other CME providers for a total of 710 hours of American Medical Association Category I credit. Additionally, members of the Committee have actively served as members of site survey teams for the accreditation of hospital-based programs of continuing medical education. The activities of the Committee continue to assure physicians of Florida that educational programs offering AMA Category 1 credit are of the highest quality. (Referred to R.C. I)
4. **Medical Student Loans:** The Foundation's Medical Student Loan Program is still under a moratorium, which has been in effect since 1977. The nine loans for which the Foundation repaid the bank in 1981 are slowly being repaid to the Foundation. The outstanding balance on these loans is currently $21,204.78. Payments are being made regularly on four of the loans; three have been turned over for collection through legal channels; and two are pending litigation.

 In June, 1984, the Foundation was asked by the Florida National Bank Trustee for the Guaranteed Medical Student Loan Program, to repay another $31,645 in delinquent loans of eight recipients. Concentrated collection efforts have been directed toward these by the Foundation, and they are now in varying stages of repayment. The outstanding balance of these now stands at $27,555.79. The recipients are being charged interest on their respective unpaid balances at 10% per annum until the balances are repaid.

 With the continuing efforts and attention being given to the collection of these loans, we are optimistic that the outstanding balances will be reduced considerably during the next year.
5. **Florida Medical Association Auxiliary:** The Foundation is indebted to the Florida Medical Association Auxiliary for its loyalty in supporting the Foundations' programs.

 In addition to its representative on the Committee on Impaired Physicians, the Auxiliary raised $5,000 in funds which it donated to the Foundation, earmarked for use in the Impaired Physicians Program. The Auxiliary has also designated the proceeds from the second printing of its cookbook, entitled "RX for Fine Dining", to be donated to the Foundation for the Impaired Physicians Program.
6. **Professional Review Organization of Florida, Inc.:** The Professional Review Organization of Florida, Inc., (PROF) submitted a detailed two volume proposal to be designated the statewide PRO to the Health Care Financing Administration on April 27, 1984. Subsequently, the PROF submitted a revised proposal on June 15, 1984. On June 26, 1984 the PROF entered into negotiations with HCFA officials and as a result was asked to submit a "Best and Final" offer on July 5, 1984. The contract was awarded on July 13, 1984 to the Professional Foundation for Health Care (the existing PSRO in Tampa, Florida). The PROF, Inc., requested HCFA to provide detailed information on the reasons why the contract was awarded to the Professional Foundation for Health Care, Inc., and as a result participated in a debriefing session in Baltimore, Maryland with the HCFA negotiating team on July 25, 1984. As a result of the award of the contract, the FMA Professional Review Organization of Florida, Inc., filed a protest with the United States General Accounting Office (GAO). In addition, the PROF has filed a lawsuit under the Freedom of Information Act because of HCFA's unwillingness to supply the PROF with pertinent information regarding the Professional Foundation for Health Care's proposal. A hearing was held with the GAO on October 25, 1984. No decision to date on the protest or lawsuit has been rendered. (Referred to R.C. V)



Margaret C.S. Skinner, M.D., Chairman, Reference Committee III, addressed the House of Delegates.

Supplemental Report
Florida Medical Foundation

The Supplemental Report of the Florida Medical Foundation was adopted as presented.

This Supplemental Report updates the report of the Florida Medical Foundation in order to report on recent activities that have occurred pertaining to the Professional Review Organization of Florida, Inc., the FMA's entity, that submitted a PRO proposal to the Health Care Financing Administration (HCFA).

The following is a chronological order of events that have taken place since the Peer Review Organization of Florida, Inc. submitted a proposal to the Health Care Financing Administration to be designated the statewide PRO.

On April 27, 1984, the Professional Foundation of Florida, Inc., submitted their two-volume proposal to be designated as the statewide PRO. This proposal included both a business and technical proposal.

During the week of April 14 to April 18, 1984, the PROF's business proposal was intensely reviewed by Arthur, Anderson and Company, CPA firm, who gave the business proposal a favorable audit.

On June 8, 1984, the PROF was requested by HCFA to provide additional supplemental materials and to elaborate on several questions that were asked. A detailed 600-page Supplemental Report was prepared in less than a week and submitted to HCFA on June 15, 1984.

On June 25, 1984, the PROF entered into negotiations with the Health Care Financing Administration to be designated the statewide PRO and at that time were requested to submit a best and final offer on July 5, 1984.

On July 13, 1984, the Health Care Financing Administration awarded the statewide PRO contract to the Professional Foundation for Healthcare, Inc. (Tampa PSRO).

On July 18, 1984, after assistance from the Florida House and Senate Delegation, the Florida Medical Foundation's Peer Review Organization of Florida, Inc., conducted a conference call with HCFA officials to determine the reasons why the contract was not awarded to the Professional Review Organization of Florida, Inc.

On July 19, 1985, the Professional Review Organization of Florida, Inc., filed a protest with the General Accounting Office of the United States Government. This protest was based on the fact that:

1. The contracting authority omitted in the request for proposal specific sections, essential terms, thereby putting the Professional Review Organization of Florida, Inc. at a distinct disadvantage in a competitive bid;
2. The criteria for evaluating proposals was not set forth in a clear and understandable manner;
3. The contracting authority failed, during the negotiations, to ask appropriate questions and to impart intellegible information to the Professional Review Organization of Florida, Inc., which put the Professional Review Organization of Florida, Inc. at a distinct disadvantage;
4. The contracting authority supplied erroneous information;
5. The contracting authority failed to recognize the Professional Review Organization of Florida, Inc.'s vast amount of peer review experience accumulated over the last 10 years; and
6. The Professional Review Organization of Florida, Inc. also based their protest on the fact that significant criteria was utilized to determine the awarding of the contract which was not included in the request for proposal.

On July 23, 1984, the Professional Review Organization of Florida, Inc., requested under the Freedom of Information Act information pertaining to the awarding of the contract including details as to what areas the competitors had significant gains in the awarding of points as well as any other information used to make this determination.

On July 25, 1984, the Professional Review Organization of Florida, Inc., met with HCFA officials in Baltimore for a debriefing session. At that time the PROF was advised of the reasons why they were not awarded the contract. Based only on the PROF's proposal, no information was given about the proposal that was awarded.

On August 20, 1984, the Professional Review Organization of Florida, Inc. filed suit against the Department of Health and Human Services for failure to provide information as requested under the Freedom of Information Act in a timely manner.

On October 25, 1984, the Professional Review Organization of Florida, Inc., participated in a General Accounting Office hearing held in Washington D.C. As a result of this hearing, the Professional Review Organization of Florida, Inc., submitted an amended protest based on information presented by Mr. Salazar of the Florida Peer Review Organization, Inc., who specifically stated that he was told during the negotiation session that their organization should attempt to achieve a 10% impact on state Medicare admissions as part of its best and final offer. The Peer Review Organization of Florida, Inc., did not receive such guidance and, in fact, were told to achieve a 4.5% to 5% deduction in total Medicare admissions within the state.

On April 5, 1985, the Professional Review Organization of Florida, Inc., was notified of the decision of the hearing with the General Accounting Office of the United States Government. The protest of the Professional Review Organization of Florida, Inc., was denied by the GAO.

The Professional Review Organization of Florida, Inc., and the FMA Committee on PRO is currently reviewing the results of the protest and the freedom of information act lawsuit, recommendations of the law firm of Williams and Connolly, and will make recommendations to the Board of Governors at the June Meeting.

Florida Medical Foundation
Committee on Impaired Physicians

The Report of the Florida Medical Foundation Committee on Impaired Physicians was adopted as presented.

Florida Medical Foundation
Committee on Impaired Physicians
Guy T. Selander, M.D.

A year-long search for a full-time medical director for the FMA-FMF Impaired Physicians Program has been successful, making 1984-85 another landmark year for the Committee on Impaired Physicians.

In February, the Committee on Impaired Physicians and the FMA Executive Committee agreed to offer the position to Roger A. Goetz, M.D., a Milwaukee native who most recently was located at Columbia, S.C. Dr. Goetz, an anesthesiologist by training, has been involved in the treatment of impaired physicians for several years. He is a member of the Board of Directors of the American College of Addictionology.

Dr. Goetz assumed the position in February, succeeding Dolores A. Morgan, M.D., of Miami, who has served ably as medical director of the IPP on a part-time basis since the inception of the program in the Fall of 1980. Initially, Dr. Goetz will maintain his office in Jacksonville, which is subject to change later.

Dr. Goetz's duties will include liaison with the Florida State Board of Medical Examiners and organizations of health care professionals that maintain impairment programs; liaison with

county medical society impaired physicians committees; formation of intervention teams; refinement of the treatment facility accreditation process; arrangement of educational programs; speaking engagements before lay and professional groups; and coordination of after care monitoring.

Following is a summary of other activities of the Committee on Impaired Physicians over the past year:

1. **Reporting to DPR:** After months of negotiations, the Committee reached agreement with the Florida Department of Professional Regulation regarding the reporting of cases as required by S. 458.3315(5) (a), F.S. Under the agreement, treatment program directors are to report each physician admitted for treatment to the Board of Medical Examiners' impaired professionals program consultant. Physicians will not be identified by name but by an "addiction treatment number". In the event a physician patient drops out of treatment or is considered a danger to patients, he or she shall be reported to the consultant by the treating physician. If, after consultation the consultant determines that a complaint should be filed with DPR, the treating physician or medical director will furnish the name to the consultant.
2. **Treatment Facilities:** The Committee approved two additional treatment facilities during the past year. These are Mt. Sinai Medical Center of Miami Beach and Bowling Green Inn. Several other facilities were reviewed but not approved because they did not meet one or more of the Committee's criteria.
3. **Section on Chemical Dependency:** For the fifth consecutive year, the Committee is sponsoring a Section on Chemical Dependency at the FMA Annual Meeting. "Substance Abuse: Consequences and Implications" will be the theme of this year's program, which is scheduled for 1:00 p.m. to 4:00 p.m. on Thursday, May 2, at the Diplomat Hotel in Hollywood.
4. **Gift to AMA:** The Committee made a gift to the American Medical Association of a framed Lee Adams *Caduceus* print. The art piece bears the inscription "Presented to the American Medical Association by the Florida Medical Association Committee on Impaired Physicians, June 1984", and it will be on permanent display in the AMA Chicago headquarters.
5. **EMTS and Paramedics:** The Committee provided without charge consultative service to the Florida Office of Emergency Medical Services regarding the development of a program for impaired emergency medical technicians and paramedics.
6. **Lectures and Speeches:** Members of the Committee continued to be available to address various audiences on the matter of impairment and related subjects. Some of the notable appearances this year included the medical director's talk on dealing with stress and avoiding burnout at the FMA's "Leadership Skills Seminar for Women Physicians" on February 1; and the Chairman's presentation at the first Statewide Conference on Prescription Drug Abuse in Tampa, October, 1984.

Florida Medical Political Action Committee (FLAMPAC)

The Report of the Florida Medical Political Action Committee was adopted as presented.

Florida Medical Political Action Committee (FLAMPAC)

Robert E. Windom, M.D., President

Political Action Program - 1984

1984 was an extremely successful year for the Florida Medical Political Action Committee. The election results were much improved over the 1982 election. An increased number of physicians and their spouses participated as volunteers in individual legislative and congressional races, and the financial contributions to FLAMPAC far exceeded any previous years' total.

These successes have created a significant reserve account that can be carried forward as a base for increased volunteer recruitment, training and development of additional resources, e.g., polling, independent expenditures, etc., that can be brought to bear during the 1986 election.

The continuing organizational and personal support provided to FLAMPAC by the members of the FMA Board of Governors and the FMA Executive Director has made these achievements possible and will ensure the continued growth and maturing of medicine's statewide political action arm.

The General Election was a most successful one for FLAMPAC. We were on the winning side on all 11 congressional candidates supported, won five of six for Florida Senate and won 41 of 47 House of Representatives' races. This is an overall winning percentage of 87.5%.

Of the Florida Senate and House races in the General and Primary Elections, 32 of 35 "Friends of Medicine" were re-elected. In the General Election, we were successful in 26 of 29 races that the Board determined to be of critical importance. Three physicians - Senator William G. Myers, M.D. (R), Representative Bernard Kimmel, M.D. (R) and Representative David Thomas, M.D. (R) and one physician's spouse, Representative Betty Metcalf (D) were elected. (Dr. Thomas is the new addition to the "medical family" members in the Legislature.)

There was no change resulting in the elections among the House and Senate Democratic leadership, but it appears that our base of support on the floor of the House has been strengthened.

Membership

Final FLAMPAC membership contributions in 1984 exceeded the quota established by more than $48,000. This occurred in spite of a lower than projected membership total. A significant achievement is the record number of 4,697 individuals who joined FLAMPAC as Sustaining Members.

This increased financial support by physicians and their spouses enabled FLAMPAC to play a significant financial role in congressional and legislative races. In addition, the individual monetary and voluntary contributions at the local level provided the margin of victory in several key legislative races.

For the first time AMPAC has recognized state medical associations in a new membership activity that ranks states based upon the AMPAC year-to-date membership as compared to the AMA's membership prior year figures for the particular state. For 1984, Florida ranked number one among all state medical association political action committees with a lead of 9 percentage points above second place Texas Medical Political Action Committee.

FLAMPAC Officers and Board

The FLAMPAC Board of Directors elected the following persons as officers for FLAMPAC during 1985:

Robert E. Windom, M.D., President
James G. White, M.D., Vice President
Carlos G. Llanes, M.D., Secretary
Louis C. Murray, M.D., Treasurer
Donald C. Jones, Assistant Treasurer

The FMA Board of Governors as provided in the FLAMPAC Bylaws has appointed an outstanding list of physicians and their spouses to serve as the FLAMPAC Board of Directors during 1985. Persons appointed to the FLAMPAC Board of Directors for 1985 are:

Florida Congressional Districts:
William W. Thompson, M.D. (1st)
Terence P. McCoy, M.D. (2nd)
Mrs. James H. Corwin (3rd)
James G. White, M.D. (4th)
Louis C. Murray, M.D. (5th)
Frank R. Wilkerson Jr., M.D. (6th)
Frank C. Coleman, M.D. (7th)
James L. West, M.D. (8th)
Donald G. Nikolaus, M.D. (9th)
John W. Glotfelty, M.D. (10th)
Brian P. Gibbons, M.D. (11th)
Paul W. Taylor, M.D. (12th)
Robert E. Windom, M.D. (13th)
Dick L. Van Eldik, M.D. (14th)
T. W. Hahn, M.D. (15th)
Stanley I. Margulies, M.D. (16th)
James W. Bridges, M.D. (17th)
Margaret Skinner, M.D. (18th)
Warren Lindau, M.D. (19th)

Members of FMA Auxiliary:
Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Donald G. Nikolaus

Liaison Representatives from FMA Board of Governors:
Luis M. Perez, M.D.
Kay K. Hanley , M.D.

Members of FMA Council on Legislation:
Thomas M. Daniel, M.D.
Michael J. Pickering, M.D.

Members from the State At-Large:
H. Quillian Jones Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

President-Elect of FMA Auxiliary:
Mrs. Milton Tignor (Ex-officio)

Florida Physicians Association

The Reference Committee heard extensive testimony regarding the history of the Florida Physicians Association and of the potential areas in which the Association has been and can be of benefit to the membership.

The motion of the Reference Committee recommended that the Report of the Florida Physicians Association be referred to the Board of Governors and that the Board make a diligent effort to explore a broader scope of activities for the Florida Physicians Association that will effectively address those medical economics' issues affecting physicians deemed appropriate, and which are outside the purview of the FMA and its component county medical societies carried.

Florida Physicians Association

David T. Overbey, M.D., President

The Florida Physicians Association is a non-profit corporation founded in December 1972 to protect the private practice of medicine by becoming involved in activities that the Florida Medical Association cannot enter into because of Charter restrictions and legal ramifications.

As of the date of this report, the Florida Physicians Association has 3,078 members and is expected to grow even larger by the Annual Meeting.

During the past year, the Florida Physicians Association has been requested to provide financial help in countering alleged false advertising and deceptive practices of Health Maintenance Organizations. Action on this issue has been deferred until the Annual Meeting of the Florida Physicians Association.

The Florida Physicians Association was contacted to help provide financial aid for the Reason '84 constitutional amendment campaign. The FPA Board of Directors was polled by phone and with majority consent a substantial financial donation was made to the Campaign.

The Florida Physicians Association meets regularly at the time of the FMA Annual Meeting and reports to the FMA Board of Governors.

It is our hope that this organization will be able to preserve, protect and defend the private practice of medicine and the people of Florida from charlatans and purveyors of questionable business practices more interested in their profit rather than the welfare of the people and the individual medical practitioner.

Florida AMA Delegation

The Report of the Florida AMA Delegates was adopted as presented.

Florida AMA Delegation

Charles K. Donegan, M.D., Chairman

It has been a pleasure for me to serve as Chairman of your Florida AMA Delegation during the past year, ably assisted by our Vice Chairman, Joseph C. Von Thron, M.D.

The effectiveness and influence of our delegation at the national level is due to the time and effort given freely by your delegates and alternate delegates. A great deal of appreciation goes to:

T. Byron Thames, M.D., Delegate
Samuel M. Day, M.D., Delegate
Burns A. Dobbins Jr., M.D., Delegate
Richard G. Connar, M.D., Delegate
Charles J. Kahn, M.D., Delegate
Joseph C. Von Thron, M.D., Delegate
Louis C. Murray, M.D., Delegate
Robert E. Windom, M.D., Delegate
Luis M. Perez, M.D., Delegate
Sanford A. Mullen, M.D., Delegate
Vincent P. Corso, M.D., Alternate
James B. Perry, M.D., Alternate
Frank C. Coleman, M.D., Alternate
Eugene G. Peek Jr., M.D., Alternate
Vernon B. Astler, M.D., Alternate
O. William Davenport, M.D., Alternate
James W. Walker, M.D., Alternate
Joseph T. Ostroski, M.D., Alternate
Arthur L. Eberly Jr., M.D., Alternate
Dick L. Van Eldik, M.D., Alternate
William B. Deal, M.D., Alternate

We are pleased to announce that our caucuses had present the delegates from Puerto Rico, Fernando J. Cabrera, M.D., and Emilio Arce, M.D.; the delegates from the Virgin Islands, Felix Pitterson, M.D., and Howard E. Hill, M.D.; and the AMA Delegate from Guam, Leon L. Concepcion, M.D.

In addition to our delegation, we were joined by many county medical society representatives and representatives from Florida to the Hospital Medical Staff Section.

The AMA was faced with another year filled with a broad range of issues. The following is a summary of major actions taken by the House and of the activities of our Florida delegation during the Annual Meeting, June 17-21 and the Interim Meeting, December 2-5. The activities of your delegates have been reported to the FMA Board of Governors and the FMA membership through various Association publications.

1. **Southeastern Delegation:** Your delegation was again active in the Southeastern Delegation which is composed of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

Activities included a breakfast caucus on Sunday morning, at which time major items of business to be addressed by the House were discussed, and receptions were hosted at noon on Sunday, and on Monday and Tuesday evenings.

2. **Resolution:** The Florida Delegation introduced a resolution at the AMA Interim Meeting. Resolution 43, Peer Review Organizations, was considered along with other state resolutions regarding various aspects of the Health Care Financing Administration's (HCFA) implementation of Peer Review Organizations.

RESOLVED, that the American Medical Association convey to the Secretary of the Department of Health and Human Services that the Peer Review Organization Program, created as part of the Tax Equity and Responsibility Act of 1982 (PL 97-248) and as implemented through the Request for Proposal, has made cost saving quotas more important than insuring the quality of medical care; that the admission and quality objectives of individual bidders were analyzed on a subjective basis; that the Health Care Financing Administration (HCFA) failed to pursue serious flaws in several "winning" proposals which suggests that the personnel conducting the evaluations were incompetent in performing their jobs; that the legislative intent in creating PROs has not been adhered to; that physician-sponsored organizations have been purposely excluded; and that the basis on which contracts awarded to date will result in the loss of millions of taxpayers' dollars; and be it further

RESOLVED, that the AMA conduct an immediate and comprehensive review of the Tax Equity and Responsibility Act of 1982 (PL 97-248) and the manner in which it is being applied by HCFA of the Department of Health and Human Services and recommend any appropriate legal or legislative actions to remedy the deficiencies cited herein.

The following is a summary of other major actions taken by the AMA House of Delegates:

1. **Future Directions and Resource Needs:** The House approved several recommendations of the Board of Trustees contained in a major report regarding AMA finances and membership.

— Of foremost interest to AMA members is that AMA dues will be maintained at current levels in 1985. The Reference Committee cautioned the House, however, that future AMA dues may have to be increased by $30 in 1986 and an additional $30 in 1987 in order to avoid major reductions in AMA programs and activities in those years.
— State medical associations will be allocated one extra delegate when 75 percent or more of the state society's members are also AMA members. Unified states (Illinois and Oklahoma) will be granted two additional delegates.
— The dues exemption policy was revised so that this membership category is limited to members who are at least 70 years of age and fully retired or suffering financial hardship and/or disability.
— Members who are at least 70 years of age and working not more than 20 hours per week pay one-half of regular dues.
— Members who previously qualified for dues-exemption under criteria other than financial hardship would continue to be eligible under the grandfather clause.
— The Judicial Council was expanded from five to seven members to aid the Council in its effective consideration of a growing number of ethical concerns.

2. **Diagnosis-Related Groups (DRGs):** Easily the dominant issue at the Annual Meeting was DRGs and their effect on the quality, cost, and availability of care. The House directed the Board to place a high priority on monitoring the system and report back at the 1984 Interim Meeting. In other related actions, the House voted to:

— Continue the AMA's strong and concentrated efforts to seek elimination of the DRG attestation statement that requires physicians to certify primary and secondary diagnosis and procedures.
— Seek legislative and regulatory changes to ensure that differences in DRG-based payments to different categories of hospitals (rural and urban) are based on true differences in the costs of providing services by those hospitals rather than on arbitrary geographic criteria.
— Oppose the mandated algorithmic or cookbook/decision tree method of establishing a treatment regimen as cost effective under the Medicare payment system.
— Oppose the expansion of DRGs to physicians.
— Seek changes in the DRG system to provide adequate reimbursement for events arising during hospitalization that significantly add to a patient's requirements for care.

3. **Health Policy Agenda:** A special reference committee was appointed to consider the 159 principles developed by the Health Policy Agenda for the American People. These principles are broad value statements about what should exist in the health policy arena. Instead of adopting the principles as AMA policy, the House voted to endorse them as working principles to help guide AMA representatives to HPA Work Groups and Advisory Committees throughout the remainder of the project, scheduled for completion in 1986. In its next phase, the HPA will translate the principles into policy recommendations and action plans.
4. **Automobile Safety:** The House considered several resolutions related to the use of air bags and seat belts. The House supported:

— Mandatory installation of air bags in domestic and foreign cars.
— Legislation promoting the availability of seat belts in all motor vehicles, including buses and taxis, used to carry passengers.

— Mandatory seat belt use laws.
— Mandatory child passenger restraint laws.

5. **Tobacco and Health:** Taking an aggressive anti-smoking stance, the House approved several policies to position the Association in the forefront of anti-smoking groups. The House voted to:
 — Urge Congress to strengthen warnings on cigarette packages to say that smoking causes cancer of the mouth, larynx, and lung; is a major cause of heart disease and emphysema; is addictive; and may result in death.
 — Study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation.
 — Ask the Surgeon General to place health hazard warnings on all snuff and chewing tobacco packages.
 — Encourage physicians to schedule extra time to explain the health hazards of smoking to their patients.
 — Urge hospitals, offices, and all other medical care facilities to declare themselves off limits to smoking.
 — Work to protect the health of non-smokers on airplanes.
6. **Hospital Medical Staff Issues:** The Hospital Medical Staff Section met for two days prior to the opening of the AMA House. Over 700 representatives were registered from virtually every state. They considered about 60 resolutions and submitted 18 resolutions for consideration by the AMA House. Enthusiasm among HMSS representatives remains high and participation in this policy-making process is expected to increase. The goal is to have every hospital send a representative to further enhance communication between the AMA and local hospital medical staffs. The AMA House approved a number of resolutions related to the organization and operation of the medical staff. The House:
 — Supported the medical staff's authority to approve or disapprove all amendments to medical staff bylaws.
 — Supported the idea that hospital governing boards cannot unilaterally change medical staff bylaws.
 — Asked the AMA to prepare and distribute a document on the legal status of medical staffs.
 — Encouraged hospitals and medical staffs to make all medical staff rules available to physicians.
 — Directed the AMA to oppose any regulation that would mandate voting privileges for non-physician members of the medical staff.
 — Recommended that medical staffs develop bylaw provisions that affirm the binding effect of medical staff bylaws on the hospital governing board and the medical staff.
7. **Professional Liability:** On the last day of the meeting, the Board of Trustees submitted a report informing the House that a special task force would be established to study professional liability. The task force is charged with coordinating current AMA activities and focusing them on professional liability insurance. AMA Executive Vice President, James H. Sammons, M.D., will chair the task force. Other members include AMA General Counsel, the Assistant Executive Vice President, and two Deputy Executive Vice Presidents. The Board will submit a report at the 1984 Interim Meeting.
8. **Cognitive Services Reimbursement:** The House considered five resolutions pertaining to reimbursement for cognitive services. The House approved a substitute resolution that asked the AMA to:
 — Support the concept that third party payors should provide more equitable reimbursement for physicians' services which are solely cognitive in comparison with their procedural services.
 — Take appropriate action to promote more equitable reimbursement for solely cognitive services with third party payors, business groups, and other professional associations.
9. **Illegal Medical Degrees:** The House voted to continue to assist appropriate private and governmental agencies in identification of persons possessing illegally obtained medical degrees.
10. **Maternity Leave for Residents:** The House adopted a report that recommends that residency program directors develop a written policy on maternity leave for residents.
11. **Protective Headgear for Horseback Riders:** The House approved the following guidelines regarding participation in horseback riding activities:
 — Educational programs be given to parents, riding instructors, show organizers, and managers outlining the risks in horseback riding and methods to minimize them.
 — Satisfactory, protective headgear be selected for each type of riding activity and when riding or preparing to ride.
 — Individuals riding horses be encouraged to wear protective headgear.
12. **IRS Physician Impersonation:** The House received a late resolution pertaining to a recently announced IRS campaign to have IRS agents impersonate physicians and other professionals. The House asked the AMA to monitor the situation and report back at the 1984 Interim meeting.
13. **Boxing:** The House considered four resolutions calling for opposition to the sport of boxing. The House combined these resolutions into a clear statement that places the Association in the forefront of organizations calling for a total ban on boxing. This issue received much national media attention. The House called on the AMA to:
 — Encourage the elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury.
 — Communicate its opposition to boxing to appropriate regulating bodies.
 — Assist state medical societies to work with their state legislature to enact laws to eliminate boxing in their jurisdictions.
 — Educate the American public, especially children and young adults, about the dangerous effects of boxing on the health of participants.
14. **Chelation Therapy:** Another timely issue involves use of chelation therapy. The House spent much time in developing a policy statement on this controversial treatment. The policy reads as follows:

 RESOLVED, AMA reports show that there is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, atherosclerosis, rheumatoid arthritis, and cancer; and be it further

 RESOLVED, That if chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hypercalcemia, or digitalis toxicity, it is the responsibility of its proponents to (a) conduct properly controlled scientific studies, (b) adhere to FDA guidelines for the investigation of drugs, and (c) disseminate results of scientific studies in the usually accepted channels.

15. **Professional Liability:** The House approved two progress reports on the Association's activities in professional liability. One report presents the results of the AMA Committee on Professional Liability's study of costs, tort reform, and other aspects of this complex problem. The Committee was established in 1982. Another report on the activities of the Special Task Force on Professional Liability was established by the Executive Vice President last June. The Task Force's purpose

is to coordinate, prioritize, and expand the AMA's activities in the professional liability area.

16. **Public Image of Physicians:** Concern for negative public opinion toward physicians was uppermost in the minds of the delegates. The House approved a comprehensive and thoughtful report on the Association's current activities and plans for improving the public image of physicians. The report noted:

 — "Organizational efforts to improve the public image of physicians are inherently limited and can never replace the actions of individual physicians committing themselves to spending more time with patients, giving them better instructions, and discussing their fees."
 — Public perceptions take many years to form, and since the problem has been developing for a long time, it will not be solved quickly.

 * Public perceptions of physicians are often inconsistent, and at times contradictory depending upon the background and experience of the individual.
 * Public expectations, another image issue, are often unattainable.

 In addition to the above report, the House adopted a substitute resolution formulated by the Reference Committee. It called upon the AMA to:

 — Strengthen its efforts to increase the public's awareness that physicians are patient advocates.
 — Develop and implement an immediate program to focus on increasing the public's understanding of key changes that are occurring in the health care delivery and the impact that such changes will have on health care quality and access.
 — Plan a long-range national public education campaign utilizing consultants with established reputations.
 — Provide assistance and encouragement to state and county associations to develop and implement similar public awareness programs and monitor and evaluate such programs for their effectiveness.

17. **Benefits of Unified Membership:** The House approved several recommendations of the Board of Trustees providing additional benefits to members in unified states. The new benefits are designed to encourage and retain unification. Currently, only Oklahoma and Illinois are unified states. The new benefits include:

 — Services of an AMA ombudsman within the organizational structure.
 — Ten percent dues discount for members excluding students and residents.
 — Staff services for specialty projects.
 — Specialty briefings for officers of unified societies.
 — A specialty Advisory Committee to meet regularly with the Executive Committee of the Board of Trustees and the EVP.
 — A higher reimbursement rate to constituent societies for dues collection.

 Also, the House asked the Board of Trustees to study alternative mechanisms to provide membership incentives for all state, county, and specialty societies who have successful recruitment programs.

18. **AMA Budget:** The House approved a fiscal year 1985 budget based on operative revenues of $125,430,000 and operating expenses of $124,580,000 with an anticipated favorable balance of $1,850,000. Incorporating an AMACO gain of $670,000 and a provision for income taxes of $930,000, the anticipated revenue in excess of expense is $1,590,000.

 There is no dues increase for 1985.

 Before the House considered the budget, the Reference Committee cautioned the delegates that the $1.6 million is a narrow margin and about 1% of the total budget. It imposes severe limitations on the growth of activities that can occur in the year ahead without additional revenues or displacement of existing activities.

19. **Peer Review Organizations:** The House considered six resolutions, including Resolution No. 43 presented by the Florida Medical Association, regarding various aspects of HCFA's implementation of PRO. There were several speakers who emphasized the difficulties of negotiating realistic performance objectives in the PRO contracts. Also, the delegates complained about the inappropriate emphasis on cost containment rather than the quality of services provided. The House directed the AMA to:

 — Continue its support for professionally directed programs of medical peer review which places the emphasis on quality rather than cost.
 — Actively oppose HCFA's use of arbitrary admission and quality objectives in the activities of PRO.
 — Implement a PRO monitoring system to obtain documentation necessary to redress PRO implementation problems through legislative and regulatory means.
 — Urge the Federation to collect and provide information to the Association.
 — Actively seek legislation to correct demonstrated inequities in the implementation of the PRO program.

20. **Opinions of the Judicial Council:** The House discussed and approved a number of ethical issues in considering four important reports from the Judicial Council.

 — "Physician-Patient Relationships: Respect for Law and Human Rights" which prohibits illegal discrimination in the physician-patient relationship.
 — "Terminal Illness - Patients' Preferences" which relates to "living wills" authorizing withdrawal from life support systems when the patient is irreversibly terminally ill.
 — "New Medical Procedures" which states that physicians have an obligation to share their knowledge and skills, and to report the results of their research.
 — "Surrogate Parenting" which urges couples with infertility problems to investigate the alternatives available to them, including adoption. The Judicial Council believes that surrogate motherhood presents many ethical, legal, psychological, societal, and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents.
 — "Hospital-Physician Risk-Sharing Arrangements" under DRGs which advises that physicians may not derive a profit, nor be financially penalized, nor risk loss of hospital privileges under profit or loss sharing agreements.

21. **Hospital Medical Staff Section:** With increasing maturity and sophistication, the Hospital Medical Staff Section continues to grow in influence within the House of Delegates. The HMSS at its fourth assembly meeting grappled with the problems of physician-hospital relations. Over 400 representatives attended and submitted 14 resolutions to the AMA House. Virtually every state and territory was represented and the delegates learned that 31 state medical associations have created similar sections to deal with these issues at the local level.

22. **Medical Acts by Unlicensed Individuals:** The encroachment of non-physicians into the practice of medicine stimulated four resolutions and much debate in the House. Although

AMA policy on the issue was reaffirmed, the delegates called for more aggressive actions, including:

— Monitoring legislative and regulatory activities.
— Disseminating information concerning such activity as expeditiously as possible.
— Developing a pro-active program to provide AMA legislative and staff support to assist state medical and specialty societies in their efforts to oppose enactment of new legislation which authorizes independent practice of medicine by individuals who are not licensed to practice medicine and surgery in all its branches.

23. **Scientific Reports:** The House agreed to permit the publication of reports from the Council on Scientific Affairs without the approval of the House. This new practice will allow earlier dissemination of scientific information. At this meeting the Council submitted a number of scientific reports. Topics included:

— The Health Effects of Agent Orange.
— Diagnostic and Treatment Guidelines for Child Abuse and Neglect.
— Effects of Toxic Chemicals on the Reproductive Cycle.
— Nicotine Chewing Gum for Cessation of Smoking.
— Guidelines for Reporting Estimate of Probability of Paternity.

24. **AMPAC Year-End Report:** The American Political Action Committee (AMPAC) enjoyed a record-breaking year in 1984, AMPAC Chairman Fred J. Rainey, M.D., told the AMA House of Delegates. During the 1983-84 election cycle, Dr. Rainey said, AMPAC participated in 578 campaigns, with a 90% success rate. He noted that this included support for 233 Democrats and 345 Republicans, providing the bipartisan nature of the organization and demonstrating that "party labels have no place in our decisions." Dr. Rainey also said that AMPAC membership now stands at a record 55,500 and that the organization had raised some $3.7 million in campaign funds in 1983-84; up from $2.4 million in the previous election cycle.
25. **AMA Membership Contest:** I am pleased to announce that the Florida Medical Association was awarded a first place trophy for states with over 11 delegates in the AMA new membership contest. Congratulations to Richard G. Connar, M.D. for producing the most new members in the group, and to Robert E. Windom, M.D. who was second in total number of new AMA members.

Report C of the Board of Governors

The Reference Committee commended the Board for its outstanding performance during this unusually difficult year and suggested particular action on the Recommendations as follows:

Recommendation No. C-1 was adopted as presented.

Recommendation No. C-2 was adopted as presented.

Recommendation No. C-3 was adopted as amended with several items considered separately;

Item B was not adopted.

Item K lines were deleted so the item reads as follows, "That the FMA Annual Meeting format be reduced from a five-day program (Wednesday to Sunday) to a four-day program (Thursday to Sunday)."

Item O was amended to read, "That the House of Delegates expressed strong support and approval for the recommendation that each specialty group recognized by the FMA have a voting delegate and alternate delegate in the FMA House of Delegates provided no delegate would have more than one vote, and each delegate be a member of the Florida Medical Association, and further, that the appropriate amendment to the FMA Bylaws be adopted to reflect this action. . ."

Report C of the Board of Governors was adopted as amended.

Report C of the Board of Governors

Frank C. Coleman, M.D., Chairman

On behalf of the Board of Governors, your Chairman is both proud and pleased to submit this report to the House of Delegates regarding the many activities of the Board of Governors and the Association's Councils and Committees during the past Association year.

The following report and the others throughout the Delegates' Handbook address the many vexing and difficult issues and problems currently being faced by medicine.

This past year has been a particularly difficult one, as we were faced with the tremendous challenge of a constitutional initiative campaign to resolve the professional liability crisis, which continues to plague physicians and the citizens of our state. We were also faced with the unexpected financial crisis effecting the Florida Physicians Insurance Reciprocal and the task of insuring the continuity of professional liability protection for those physicians who received their PLI coverage through the Reciprocal. It has also been a year of tremendous and sweeping change within your Association, changes I am confident will greatly enhance our ability to serve the needs of FMA members in the future. These important issues and changes are fully addressed in this report, as well as other sections of the Delegates' Handbook.

As I began my term as President on May 6, 1984, I extended a call for unity and participation; one profession — one Association — one future. We, as physicians, are in a time of great change, a change that is so dramatic and so sudden that it has dazzled many of us. It is clear that changing values and economic necessity are primarily responsible for this change. The public does not look upon doctors as it did a generation ago, and both business and government are rebelling against the high cost of health care. The question now is whether the cost of health care should be controlled by the competitive approach or by the regulatory approach. Unfortunately, with cost containment as the watchword, little is being said about the impact of cost containment on the quality of care.

Prospective payment for hospitals for Medicare patients using DRGs is now a reality and this same concept may well be extended to physicians. Our Legislature has been debating whether to give the Hospital Cost Containment Board the authority to regulate hospital rates for private patients. Physicians are being pressured to accept assignment on both Medicare and private patients. HMOs and PPOs are springing up like weeds.

There is increasing discussion about rationing of care and the ethical problems involved in care of the terminally ill.

In some specialties, we have an oversupply of physicians. This excess of physicians leads to intense competition for patients and makes participation very attractive in some of the non-fee-for-service delivery systems.

It is imperative that we remember that our obligation as physicians, as it always has been, is to provide quality medical care regardless of the changing times. This is a sacred trust and must be defended with all our strength.

The House of Medicine must make whatever adjustments should be made to defend this trust. The roof covering the House of Medicine must be broad enough for every physician to participate in the decision-making of the Florida Medical Association and in the implementation of these decisions.

Regardless of the specialty we practice, no matter what our mode of practice, we are all physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

The state Association, in cooperation with all of the county medical societies and specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and a philosophy that meet the needs and further the goals of all physicians, regardless of their individual attributes and circumstances.

What happens to one of us, happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians, or we all fail. Whatever differences exist, our response to problems of the future — legislative, economic, professional, scientific — must be focused toward the needs of all.

Your Chairman has been honored for having had the opportunity of working with the many dedicated physicians who have actively served during the past year on the Association's Councils and Committees. I would particularly like to thank those dedicated physicians with whom it has been my personal privilege and honor to serve on the Board of Governors. Each of your Board members have given freely of their time and talents and have kept the best interest of all physicians and the betterment of health care uppermost in their minds during this difficult year and have acted thoughtfully and wisely on your behalf.

Luis M. Perez, M.D., President-Elect
James G. White, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
J. Lee Dockery, M.D., Immediate Past President — 1986
Robert E. Windom, M.D., Past President — 1985
James B. Perry, M.D., Speaker of the House
Charles K. Donegan, M.D., AMA Delegate — 1985
Ernest G. Sayfie, M.D., At Large — 1985
Gerold L. Schiebler, M.D., District A — 1986
Kay K. Hanley, M.D., District B — 1987
Dick L. Van Eldik, M.D., District C — 1985
A. Frederick Schild, M.D., District D — 1988
T. Byron Thames, M.D., FPIR — 1985
Robert N. Webster, M.D., SMBE — 1985
Mr. Christopher A. Cunha, Student Member — 1985

To my successor, Dr. Luis Perez, I extend my best wishes and my optimistic belief that his year as President will be a deeply rewarding experience, as mine has been. With the level of leadership in Florida medicine and the many dedicated physicians who give of their time and talents in behalf of their colleagues, he can only succeed.

Major Activities

1985 Annual Meeting Format: The Board established the format for the 1985 Annual Meeting at the Diplomat Hotel, Hollywood, Florida, May 1-5, 1985, and approved as the scientific theme, "Quality Medicine in a Rapidly Changing Environment."

1985 FMA Leadership Conference: The 1985 FMA Leadership Conference was conducted Friday, Saturday, and Sunday, February 1-3 at the Tampa Airport Marriott Hotel. "Quality Medicine in a Rapidly Changing Environment" was the Conference theme which offered county medical society leaders and others a comprehensive look at a wide array of issues including legislation, public relations, medical economics, and hospital medical staffs. Several general sessions highlighted the Conference along with a special "Leadership Skills Seminar for Women Physicians" and an outstanding scientific section on "Clinical and Fundamental Approaches to Cellular Engineering."

Registered attendance total 329 physicians, Auxiliary members and other guests. Physician registrants represented 23 county medical societies and 11 FMA recognized specialty groups.

The following are highlights of the major issues addressed and examined at the Conference:

For the first time, the Leadership Conference offered a Leadership Skills Seminar for Women Physicians which was held on Friday morning and sponsored by the FMA Committee on Membership Development. The basic message conveyed by the various speakers was that women physicians have an unprecedented opportunity to be influencial and to assume leadership roles in organized medicine. The half-day Conference was planned and chaired by Kay K. Hanley, M.D., of Clearwater, and Margaret C.S. Skinner, M.D., both members of the FMA Committee on Membership Development.

Rufus K. Broadaway, M.D., Registered Professional Parliamentarian and author of *How to Run a Medical Meeting* discussed such topics as debating, taking a vote, determining a quorum, the types of motions, the order of business and general strategy carried out during a meeting. Assisting Dr. Broadaway at this well-attended and highly successful workshop was Franklin B. McKechnie, M.D.

Another workshop on "How to Deal with the Media" was conducted by Mr. Clarence Jones, of Marathon, nationally recognized broadcast journalist, investigative reporter, author, and the only reporter who has ever won three duPont-Columbia Awards (broadcasting's equivalent of the Pulitzer) in 1975, 1978, and 1981. Following his entertaining style, Mr. Jones involved the audience in interviewing techniques and coached physicians and auxilians on how to speak before the camera. "Try to get across just one thought and use just one sentence," he recommended. "Most on-camera responses are rarely over ten seconds, but you can easily get your message across in that period of time." Mr. Jones cautioned that before the camera one of the greatest mistakes made is attempting to say too much.

A Friday afternoon scientific section on "Clinical and Fundamental Approaches to Cellular Engineering" was presented by Robert A. Good, M.D., Ph.D., Professor of Pediatrics and Graduate Research Professor at the University of South Florida College of Medicine. The world-recognized immunologist, researcher, teacher and pediatrician presented an exciting program on recent developments in cellular engineering which are having an impact on the treatment of such diseases as cancer and diabetes. Dr. Good emphasized the future direction of research he will be conducting as Physician-in-Chief and Chairman of the USF Department of Pediatrics at All Children's Hospital.

Saturday morning began with welcoming remarks from FMA President Frank C. Coleman, M.D., who introduced the keynote speaker at the First General Session. Dr. Coleman welcomed Paul Starr, Professor of Sociology at Harvard University and author of the bestselling book *The Social Transformation of American Medicine*. Dr. Starr told the audience about the frustration the public is experiencing over the health care system. Much of the frustration and confusion is due to competition and the rapidly changing redistribution of services. Traditional boundaries between adjacent groups such as insurance companies, hospitals and physicians are becoming blurred. New suppliers are taking away patients from private physicians. Although hospitals still accept

individual patients from individual physicians, the same hospitals are getting more patients from so-called bulk purchases through a variety of prepaid plans. The future holds enormous corporate upheaval with the rapid growth of health care systems, the vertical integration of services into single organizations and diversification of traditional health care organizations into other health-related and non-health-related businesses.

The second General Session on Saturday afternoon included a stimulating presentation on Doctor-Patient Communications. Featured Speaker was David Pendleton, Ph.D., Professor at Kings Fund College in London. Dr. Pendleton's major theme was how physicians can improve their communication skills to produce more satisfied patients.

Leadership Conference participants had an opportunity to attend Workshops on Legislation, Public Relations, Medical Economics or Hospital Medical Staffs. Topics covered in these Workshops included:

Legislation
- "The FMA Legislative Mechanism"
- The Capitol Scene
- View From the Hill — How it Works in Washington
- Specialty Groups
- Communicating With the Legislature

Public Relations
- Public relations in medical practice
- External public relations' projects for county medical societies

Medical Economics
- Status of programs of the FMA Council on Medical Economics
- Current trends in health economics and organizations
- Recent activities of government in Medicare and Medicaid programs
- The impact of health care delivery changes on the individual physician

Hospital Medical Staffs
- Key issues facing hospital medical staffs on national and state levels
- Current trends of hospital medical staffs on the national level
- The state perspective of the Hospital Medical Staff Section and how the FMA Council on Hospital Medical Staffs will operate.

On Sunday, a President's Prayer Breakfast was held, featuring James Strange, Ph.D., Dean, College of Arts and Letters, University of South Florida. Dr. Strange spoke on "Biblical Meditation." At a General Session following the Breakfast, Senator Dempsey Barron (D-Panama City) discussed professional liability and tort reform as part of an FMA Legislative Briefing. Senator Barron began his presentation by asserting that the number one problem of this state and of this nation is the cost of delivery of health care. And further, that this problem is not limited to this nation, but crosses boundaries and oceans around the world. Senator Barron feels that the resolution in Florida is to get professional liability out of the tort system, and that the only probable way this will occur is through a constitutional amendment.

Senator Barron said that for the Legislature to resolve this issue, it would take the full active support of the Governor. The Senator revealed that he has a proposal which he will sponsor in the Senate, based on the Workers' Compensation approach. He made it clear that the likelihood of its passing both chambers of the Legislature was remote at best. He said that there are two kinds of damage awards: special and general. It is the general damage awards that result in the large sums of money that we have heard about in malpractice cases. Therefore, cases should be limited to special compensation. General damages would include "pain and suffering," which is compensated for whatever amount a jury considers to be equivalent to pain and suffering.

In summary, it is clear that Senator Barron has assumed a leadership role in trying to resolve the issue of malpractice, but he cannot do it alone. Moreover, he challenged the medical profession to use its power, and hammer home a resolution to the problem, which until now has been manipulated by the legal profession and not for the benefit of the patient or his family. With this political guidance, organized medicine must utilize its combined strength to remove this impediment to physicians attempting to improve the health status of their patients.

Board Actions of Major Importance

FMA Priorities 1984-85: The Board approved the following Association priorities for 1984-85. (A report on the status of the Association's activities in implementing the priorities will be included as Appendix C-1 to the Board of Governors Report C in the Delegates' Notebook.)

Membership

- The Association will continue to work toward a permanent solution to the professional liability crisis in Florida through legislative, judicial and constitutional remedies, as indicated.
- Develop programs to increase awareness among practicing physicians of the importance of maintaining a relationship with their patients which is responsive to their medical and emotion well-being and which fosters open communications between the patient and the physician.
- Develop, in cooperation with component county medical societies, the FMA Auxiliary, and FMA-recognized specialty societies, public relations programs designed to improve the image of organized medicine and the individual physician as perceived by the news media and the public including an awareness of the contributions that the medical community makes to society at all levels through the provision of quality



Clair Marie Callan, M.D., President, American Medical Women's Association, speaks at the Symposium for Women Physicians.

health care and through the continued pursuit of advancements in medical technology and procedures to improve quality and longevity of life.

- Continued emphasis on a comprehensive and ongoing media relations program implemented in cooperation with component county medical societies.
- Continued efforts toward implementation of a statewide Impaired Physicians Program with a full-time medical director.
- Continued efforts to develop among FMA members an awareness of their individual responsibility for becoming actively involved, through organized medicine, in the decisions that will be made by the Legislature and other governmental bodies affecting the mechanisms and the level of health care delivery in Florida and throughout the country including, but not limited to, health care financing and system of health care delivery; i.e., Health Maintenance Organizations, Individual Practice Associations, Preferred Provider Organizations, Diagnostic Related Groups, health care competition, utilization review, peer review mechanisms, and other cost containment initiatives.
- Develop an awareness among FMA members of the factors underlying the increases in the cost of health care and evaluate the physician's role in addressing the concerns regarding health care costs.
- Continue efforts to improve communication and cooperation regarding programs and activities of the FMA with component county medical societies, the membership directly, and FMA-recognized specialty societies including maximum development of the GTE Telenet Medical Information Network in Florida.
- Continue to monitor the current relationships of physicians, individually and collectively, with hospitals and other health care facilities with appropriate actions, when indicated, to ensure preservation of the role of the physician as having primary responsibility and authority for the management of patient care but with productive interaction with allied health groups.
- Membership development at the county, state and national levels to include medical student and house staff representatives.
- Encourage FMA members to exercise their individual responsibility for becoming actively involved in community affairs and the political process including legislation and political action activities.
- The FMA will continue to explore every avenue to assure that physicians are equitably reimbursed for the services that they render to government-sponsored health care programs including the Florida Workers' Compensation program. The Association, following the directive of the 1983 FMA House of Delegates, will continue its efforts to achieve equitable payment for health care services which recognizes regional differentials in those counties where the total cost of health care delivery is demonstrated to be higher than the average for the remainder of the state.

Programs

- Continue efforts to inform the public, the Legislature, and the judiciary of the facts regarding the critical need to resolve the professional liability crisis and the deleterious effect that this problem is having upon the patient/physician relationship and the cost and quality of health care in Florida.
- Creation of a public awareness of the high level of quality and availability of health care in Florida and the contributions that the medical community makes on an ongoing basis to the preservation and quality of individual life, the public's health, and to the cultural growth of the community at large.
- That the Association actively participate in a cooperative effort with the Legislature, appropriate governmental bodies, and voluntary groups in the development and implementation of meaningful and equitable programs to respond to the concerns of the continuing increase in the cost of health care delivery with the primary goal of ensuring the continued provision of the highest level of quality medical care within the private free enterprise system of health care delivery including:

 1. An objective assessment and reporting on the underlying causes of rising health care costs in Florida.
 2. An evaluation of the impact of health care costs on the public with particular emphasis on Florida's increasing elderly population, the designated medically indigent, the unemployed, business and industry.
 3. Informational programs for the purpose of advising FMA members, the public, the Legislature and other governmental bodies on the positive and negative aspects of innovative initiatives and programs designed to cut or contain the cost of health care, such as Preferred Provider Organizations, Health Maintenance Organizations, Individual Practice Associations, health care competition, utilization review programs, peer review mechanisms and other cost containment initiatives.

- The Association will continue to promote and participate in programs addressing emergency medical services, the health needs of the aging, substance abuse, public health and school health that impact upon the health and well-being of all Floridians including:

 1. The implementation of the first-year recommendation of the FMF Emergency Medical Services Project.
 2. Providing medical leadership in the implementation of the AMA Prescription Abuse Data Synthesis (PADS) model through direct involvement with the appropriate state agencies and assuring a program of identification and referral of impaired physicians to the Committee on Impaired Physicians.
 3. Focusing on the problems of toxic substances in the environment and their impact on public health.
 4. Developing and promoting a uniform, statewide preathletic participation physicial examination.

- The Association will increase its efforts to establish channels of communication and cooperation with voluntary health agencies, allied health groups, the Florida Hospital Association, medical professional organizations, senior citizen organizations and third-party carriers in order to create meaningful health care coalitions in Florida to address issues of mutual concern.
- Continue to work toward a cooperative relationship with other departments and agencies of state government in health care related issues.
- Seek direct physician participation at the policymaking level for health planning and other state-administered health care programs including the rulemaking process.
- The Association will continue to oppose vigorously the practice of medicine other than by medical or osteopathic physicians.
- The Association will strive to become the acknowledged leader in Florida in the promotion and coordination of scientific and educational medical activities including:

 1. Identifying physicians and non-physicians throughout Florida who have direct responsibility for the provision of continuing medical education activities and providing them with appropriate up-to-date information on CME and accreditation procedures and requirements.

2. The development of an FMA booklet on CME explaining the Association's program.
3. Providing assistance to county medical societies, specialty societies and hospitals relative to procedures and requirements for high-quality programs of CME.

- That pursuant to the actions of the FMA House of Delegates in May 1983, the Association, through the Florida Medical Foundation or other appropriate entity, apply for designation as the statewide peer review organization (PRO) in Florida as authorized under the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248) for the purpose of promoting the efficient and economic delivery of health care services while assuring and promoting the quality of care rendered. It is the intent of the Association that, to the greatest extent possible, the FMF-PRO will through local county medical societies or their designated physician-established mechanisms implement the PRO activities at the local level. It is further the Association's intent that qualified physicians maintain primary responsibility and authority for the peer review process.

Public

- Continue to provide the public, governmental bodies and the news media with timely and responsive Association views on:

1. The seriousness of the problem of professional liability and cost of health care liability insurance in Florida and how it affects all segments of society.
2. Preventive health care educational programs.
3. Health of the public.
4. Standards for health care delivery and qualified health care professionals including health planning and qualified review of the quality and appropriateness of health care delivery.
5. The underlying factors of the cost of health care.
6. Alternative health care delivery systems.
7. Health care financing initiatives.
8. The role of government in health care delivery.

American Medical Association (AMA)

- Continue efforts for AMA membership development.
- Cooperative effort to coordinate programs and activities at all levels of the Federation.
- That the AMA be encouraged to make every effort to create a greater public awareness of the high level of quality and availability of health care in this country and the contributions that the medical community makes to society at all levels through the provision of quality health care and through continued pursuit of advancements in medical technology and procedures by physicians to improve the quality and longevity of life, and to the cultural growth of their community.
- Encourage the AMA to actively create an awareness among the Congress, other governmental bodies, and the public of the severe litigation problem in this country particularly the professional medical liability problem and the deleterious affect that it is having on the cost and quality of health care.
- The the AMA continue to address before Congress and other governmental bodies organized medicine's views on the standards for health care delivery and qualified health care professionals, the underlying factors affecting the cost of health care, the positive and negative aspects of innovative cost containment initiatives, and that the AMA continue to exert its full efforts to ensure the preservation of the country's private free enterprise system of health care delivery.

Issues

- Medical professional liability.
- Cost of medical care.
- Improving the patient/physician relationships and communication.
- Public awareness of the contributions of medicine to the quality of society.
- Continued opposition to any compulsory comprehensive national health insurance program.
- Opposition to the practice of medicine by other than medical or osteopathic physicians.
- Alternative health care delivery systems.

Awards

The Board voted to continue the following FMA awards for 1985:

Excellence in Medical Journalism
Medical Speakers Awards
Medical Malpractice Prevention Award
Harold S. Strasser, M.D., Good Samaritan Award

The Board further authorized that a special award be established for the FMA Awards For Excellence in Medical Journalism to be entitled, "The Best Of All Entries," in memory of Ernest R. Currie, Executive Vice President of the Duval County Medical Society from 1968 until his death in 1984; and further, that this Ernest R. Currie Memorial Media Award be awarded on an annual basis.

Good Samaritan Award: The Board selected two outstanding physicians as recipients of the 1985 Harold S. Strasser, M.D., Good Samaritan Award for humanitarian acts above and beyond the high standard of conduct normally expected of physicians. The awards will be presented at the First Meeting of the House of Delegates on Wednesday, May 1, 1985.

A.H. Robins Award: The Board reviewed nominations received from county medical societies and selected the recipient of the 1985 A.H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on May 1, 1985.

Distinguished Layman Award: The Board selected the 1985 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria, will be included in the Delegates' Notebook. This award will be presented at the First Meeting of the House of Delegates.

Certificate of Merit: The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1985 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Notebook for approval by the House of Delegates.

Certificate of Appreciation: The Board selected a physician to be nominated to the House of Delegates as recipient of the 1985 Certificate of Appreciation. This nomination will be included in the Delegates' Notebook for approval by the House of Delegates.

Professional Liability
Reason '84 Campaign

The 1985 Legislative Session of the Florida Legislature convenes on April 2, 1985. Many crucial issues will be debated and voted on which affect all the citizens of Florida. Among these issues will be important health care legislation. The most important of these health issues remains the professional liability crisis in our state.

The FMA has been working to bring about the enactment of long-term tort reform through the legislative process since 1975. It appears that it is no mere coincidence that malpractice suits

against doctors began to escalate shortly after the Florida Legislature, in 1971, adopted a no-fault auto insurance law. The law stabilized auto insurance rates by restricting the large number of frivolous lawsuits being filed in the state as a result of auto accidents.

In 1975, the Legislature declared in a resolution that a malpractice crisis existed in Florida because of the sudden, sharp increase in suits against doctors. Premiums soared by as much as 300% in one year, causing major insurance companies to get out of the Florida market and leaving doctors virtually no place to buy liability insurance.

The Legislature responded positively that year with two key remedies: mediation panels were created to examine the merits of cases filed against doctors, and a statute was created permitting Florida physicians to create their own insurance company to provide doctors with protection they could not at that time purchase through commercial carriers.

The mediation panels, whose purpose was to hear all medical malpractice claims and determine if there was evidence of medical negligence, consisted of a doctor and two attorneys, including a circuit court judge.

The panel's findings did not restrict a citizen's right to a jury trial. The findings could, however, be admitted as evidence in a trial. In 1976, the Florida Supreme Court ruled that the panels were constitutional.

The panels, to the consternation of the trial attorneys, proved to be an effective deterrent to non-meritorious suits. During the nearly five years in which they operated (1976-80), the panels ruled in 93% of the cases that there was no actionable negligence on the part of the doctors being sued.

Significantly, the decisions were unanimous (3-0) in 81% of the cases mediated.

The panels were attacked on two occasions by plaintiffs' attorneys and were upheld. But on February 28, 1980, with changes in court personnel, the plaintiffs' attorneys' persistent efforts were rewarded when the Supreme Court reversed itself and held that the panels were unconstitutional. The disappearance of mediation panels paved the way for a flood of new cases over the next two years, with 40% more in 1981 than 1980 and 35% in 1980 over 1979. This resulted in an increase in insurance premiums to amounts up to $70,000 annually in the high risk specialties. By 1983, based on Florida Physicians' Insurance Reciprocal records, an average of one out of every four doctors in the state could expect to become involved in a malpractice claim.

Consumers of health care, our patients, are feeling the effects of this intolerable situation right where it hurts — in their pocketbooks. Obviously, they must pay the higher cost of insurance with higher fees, but just as important, they must pay the cost of "defensive medicine," a practice used more frequently by more doctors these days as a means of self-protection against lawsuits.

Because we face the prospect of being sued if something should go wrong, many doctors order tests and other procedures they might not deem essential. The best estimate is that 30 to 40% of all diagnostic procedures ordered by physicians are attributed to defensive medicine.

In his study of the amount health consumers could expect to save over a six-year period if Amendment Nine had passed, M.G. Lewis projected a savings of $12.6 billion in six years as a result of the decrease in the practice of defensive medicine.

In addition to being costly to health care consumers, the malpractice crisis has caused a serious deterioration in doctor-patient relationships. Most doctors, particularly the younger ones, are preoccupied with the possibility of being sued.

The ever present threat of a lawsuit affects the physician's practice in several ways. It creates an anxiety in which every patient may be viewed as a potential adversary and in which the physician has begun to picture himself as an inviting target. This dangerous state of affairs not only gives rise to the practice of defensive medicine, but can and does discourage doctors from performing procedures that are worthwhile and proven but also contain a significant degree of risk. For example, a 1983 survey by the Florida Obstetric and Gynecologic Society that same year showed 25% of these doctors had stopped delivering babies and another 30% planned to stop. Again, the chief reason was the high cost of insurance and the treat of lawsuits.

The *Herald's Tropic Magazine* reported this year that Dr. George Pickel, a 46-year-old Miami obstetrician who had delivered more than 5,000 babies, had given up his medical practice to become personnel director for a car rental agency. He made the move after being slapped by two lawsuits which his insurance company settled out of court although Dr. Pickel did not feel he was responsible. He was devastated by the lawsuits, his colleagues reported.

A *Topic* survey of hospitals in Dade and Broward counties also shows that the birth rate by Cesarean section is almost 50% higher than the national average. It was explained that doctors rarely are sued if they deliver by Cesarean section and the birth is imperfect.

In Clewiston, the local hospital has closed its maternity ward because local doctors have stopped delivering babies. Pregnant women in the area must now drive 60 miles to the nearest hospital delivery room.

In 1983, after a lengthy study by respected members of the medical and legal professions, the insurance industry and members of the Legislature, FMA recommended a legislative package to resolved this crisis on a long-term basis.

Nothing in these recommendations would have restricted a citizen's right to go into the courts to recover damages for malpractice. Never has the Florida Medical Association attempted, in its legislative recommendations or in the Amendment Nine proposal, to remove the responsibility for taking care of a patient who is injured because of the short-comings of a member of the profession. When accidents occur, they should be recognized and those injured should be compensated to the extent of their need so long as that need exists.

We are deeply concerned that in many cases there is no actual malpractice; nevertheless, the jury, with considerable compassion but without much of an understanding of medicine, will dole out ten and hundreds of thousands of dollars — even millions — to the plaintiff patient. The public will pay this eventually.

The FMA also strongly believes that there is something wrong with a system that frequently gives more money to the attorney than it gives to his injured client. The University Health Trust at Jackson Memorial Hospital in Miami reported that between 60 and 70% of all monies paid out for liability would wind up in the pockets of attorneys under their contingency fee system.

As widely reported in the media, the Legislature rejected in 1983 and again in 1984 the legislative package sponsored by FMA to resolve the crisis. We should say it was rejected by the Florida House, chiefly through the efforts of the House Speaker, a trial attorney, who refused to allow it to come to the floor for debate. The Senate, by contrast, passed the package both years by substantial majorities.

Unable to get the Legislature to act, and after years of exploring ways to solve the malpractice problem, the physicians of Florida and the Florida Medical Association decided to go directly to the people with this issue. The method of amending the State Constitution through petition and a vote of the people, when the Legislature fails to act, was provided for in a 1968 revised Constitution and strengthened in 1972 by an overwhelming vote of the people.

Florida doctors were likewise committed to pass on any and all of the savings resulting from the effects of Amendment Nine to our patients. This is not a simple commitment, but a solid moral commitment made for a very simple reason — doctors believed that action must be taken to help cut costs and protect

the quality of health care.

Passage of Amendment Nine would have accomplished three objectives in civil cases. It would have eliminated the doctrine of joint and several liability which currently puts the defendant at the risk of paying 100% of the damages awarded even though he or she may have had only a minor role in the incident.Secondly, the amendment would have placed a limit of $100,000 on the amount of noneconomic damages, monies awarded for pain and suffering and other intangibles. Thirdly, Amendment Nine would have also required judges to make prompt decisions (summary judgments) in any case where there is no disagreement over the facts of the case.

Nothing in the proposed amendment restricted or limited a citizen's right to sue for malpractice, and nothing prevented a person from recovering all economic losses — loss of wages and earning capacity — and all medical expenses, now and in the future.

Physicians in Southeast Florida have borne the major brunt of this malpractice crisis. They are forced to pay an average of 45% more for professional liability insurance than their colleagues in other areas of the state. South Florida obstetricians and neurosurgeons, two of the most crucially needed specialties, are now paying upwards of $70,000 annually for their insurance.

Plaintiffs'attorneys were particularly critical of the $100.000 limitation on noneconomic damages which would also affect other damage suits. They contended that it would discriminate against low income Floridians.

What these plaintiffs' attorneys were and still are concerned about, of course, is their own pocketbooks. They customarily receive from 35 to 60% of each award as a contingency fee and the pattern of jury awards in recent years has been increasingly large sums for noneconomic damages such as pain and suffering. It is not at all uncommon these days for the plaintiff attorney to make $1 million or more on a single case.

In seeking a limit on these noneconomic awards through Amendment Nine, FMA believes that society can no longer afford to enrich people due to exorbitant noneconomic awards which society pays for through increased medical costs. Increasing medical costs are what is hurting low income people the most.

Trial attorneys attempted to mislead Florida citizens through television ads that depicted a drunk driver being "let off the hook" for running over a child. Former Supreme Court Justice Fred Karl, who joined the Reason '84 Campaign as Executive Chairman, said that this was blatantly misleading. Drunk drivers, he pointed out, go to jail, pay fines and penalties, and must compensate those they hurt for medical bills and lost wages. In cases of this type of criminal negligence, victims could also collect unlimited punitive damages, Karl said. The $100,000 cap on noneconomic damages would not apply in these cases.

The law firm of Mahoney, Hadlow and Adams of Jacksonville, one of the state's oldest and most respected law firms, agreed with former Justice Karl. Engaged by FMA to research this question, the firm reported there is precedent in law to support Reason '84's position that punitive damages would not have affected tort cases.

The Florida Supreme Court has held that the intent of the framers of an amendment, as expressed in public debate, is evidence of the public's perception and intent when they vote to approve it. Reason '84 sponsors stressed in its literature and debate that the amendment would not restrict punitive damages. Reason '84 continued to stress this point in debates and advertisements. Our intent was clear and the issue had been adequately explored.

Was Amendment Nine "recklessly tampering" with the Constitution as critics claim? Since the Constitution was revised in 1968, it has been amended 28 times and an additional nine amendments were on the ballot November 6. Could all of those 28 additional amendments be described as reckless tampering?

Was this the first attempt to limit liability in Florida? No, in 1935 Florida's *Workers' Compensation Law* was passed. It protected workers by allowing them to be adequately compensated for medical expenses and lost wages for on-the-job injuries. But in exchange for this protection, the right of workers to file suit in courts is severely restricted. In 1979, the law was reformed to virtually eliminate attorney fees which were paid on top of awards to injured workers at a cost of millions of dollars annually. In 1971, the Florida Legislature enacted the state's first no-fault auto insurance law due to thousands of damage suits being filed annually that were not only clogging the court system, but driving insurance rates upward to an extent they had become an intolerable burden. The law restricts suits and has saved Floridians millions of dollars in insurance costs.

A key question Florida citizens should ask is this — Would there have been this avalanche of damage suits against doctors if the no-fault auto insurance law had not been approved by the Legislature? Would there be this many suits if attorneys would in some way censure the large number of their colleagues who encourage damage suits through television and newspaper ads? Advertisements that have helped produce a mentality in the population that for every harm, real or imagined, there must be a remedy of money.



The Panel for the Section on Chemical Dependency was moderated by E. Joan Barice, M.D., President, Florida Chapter, American Society on Alcoholism, Palm Beach Gardens. The panelists were, left to right: Roger A. Goetz, M.D., Medical Director, FMF Impaired Physicians Program, Jacksonville; Dolores A. Morgan, M.D., Director of Addiction Services, Mount Sinai Medical Center, Miami Beach; Richard J. Feinstein, M.D., Florida State Board of Medical Examiners, Miami; Dr. Barice; Deborah Miller, J.D., Practicing Attorney, Miami.

The malpractice system that is supposed to protect the public is now being abused and all of the citizens of Florida are paying the price in higher medical bills. The Florida Medical Association embarked on this campaign because Floridians wanted action immediately against the high cost of health care. Unfortunately, the Supreme Court said no to the citizens of Florida, and again for the second time in 1984, deprived the voters of Florida their basic right to vote on a proposition that was critical to Florida's welfare.

The development of Amendment Nine and the inclusion of three provisions in the FMA proposed constitutional amendment was the result of a thorough study of those tort reform proposals that offered the greatest possible potential for effectively helping to resolve the professional liability crisis that has plagued not only Florida but many other states for over ten years. The FMA received the counsel of many knowledgeable individuals in preparing the constitutional amendment, including a special ad hoc committee on professional liability, the Association's legislative and legal consultants, which include former members and leaders of the Florida Legislature, and constitutional attorneys. The Association also received valuable input from other states and individuals knowledgeable on the professional liability issue, as well as the well-documented experience of the Florida Physicians' Insurance Reciprocal. There was a careful indepth analysis of those elements crucial to effective tort reform relief, as well as a measuring of the inherent risk of each of these elements and the volatile political environment in which we were functioning, and the single subject requirements for constitutional initiatives were carefully reviewed. The FMA's legal counsel did caution that a pending decision (which had not been made) by the Florida State Supreme Court on the Proposition 1 tax reform proposal could affect the FMA amendment if that decision was adverse. However, it was also pointed out that previous decisions of the court relative to proposed constitutional amendments in which the court had determined that the single subject requirement had been met clearly supported the constitutional soundness of the FMA proposal. In removing Proposition 1 from the ballot, the court totally reversed itself from its previous rulings and so indicated. It should also be pointed out that the court's decision on Proposition 1 did not occur until long after the time when the commitment had been made to move ahead with the FMA's tort reform proposal.

As indicated, a decision to include three directly related provisions in the FMA's amendment was based on current Florida law and substantiated by previous rulings on the single subject issue by the Supreme Court. The constitutional amendment effort was unanimously approved by the House of Delegates and was carried out by the Board of Governors whose sole concern is to represent the best interests of the physicians of Florida and their patients. It was a bold step to resolve the professional liability dilemma that is having an increasingly devastating effect on the quality and cost of health care, and which if not stemmed will literally threaten the future continuity of care. If Florida could be successful in its efforts, it could well set the stage for long sought relief in many other states who, like Florida, have been thwarted in their efforts to bring about meaningful tort reform through the legislative process. The provisions included in Amendment Nine were crucial to the attainment of that goal. It was a sound proposal. This was substantiated by one of our most revered circuit court jurists in Florida, Judge Ben Willis, of Tallahassee. In response to the challenge to the amendment by the Florida Academy of Trial Lawyers, he ruled that not only did Amendment Nine clearly meet the single subject requirement for constitutional initiatives, but that it was "enlightening." As stated at the press conference following the Supreme Court's action in removing Amendment Nine from the ballot, the court's decision was clearly politically motivated and contrary to the overwhelming will of the voters of Florida as demonstrated by more than 630,000 signed and certified petitions, the greatest number in Florida history. To think that the court's action was not greatly influenced by the tremendous economic implications of Amendment Nine for a severely flawed tort system, is folly. We should not be dissuaded by nor gullible, to the disparaging post-mortems on Amendment Nine by some of our well-intended attorney friends. There were many positive results from the Campaign. There is a strong public awareness of the severity of the professional liability problem and support for its resolution such as has not existed in the past. The Governor and other legislative leaders have publicly acknowledged professional liability as a serious problem in our state and have expressed a willingness to work for effective and equitable tort reform. As evidence of this concern, the Governor has appointed a special task force to review the problem and to report its findings and recommendations. A special business coalition task force on the professional liability problem has also been actively addressing this issue. In addition, the Florida Bar has expressed its willingness to work with the FMA in seeking solutions and we have the continuing support of many allied organizations, as well as business and industry. We need only to examine the litigious society we are all languishing in to recognize the mortal flaws in our current tort system. No doubt the drastic changes necessary to resolve this issue pose many vexing problems, but drastic changes there must be. The public deserves nothing less.

While the Supreme Court's decision was a great disappointment and a set back, the Florida Medical Association remains determined to continue its fight for tort reform. In an emergency meeting of the FMA Board of Governors held on Wednesday evening, October 3, 1984, by telephone, the Board voted to immediately consider future actions for continuing efforts to resolve this crisis including possible legal actions and further legislative actions, as well as the constitutional initiative process, if that becomes necessary.

Determined that the Association continue to exert every effort to permanently resolve the professional liability crisis, the Board authorized:

1. That the FMA President immediately appoint a special Blue Ribbon Panel to be comprised of the Council on Legislation and other prominent individuals to define and recommend a statement of policy for future tort reform efforts that will include specific legislative recommendations, constitutional initiative recommendations, petitions to the Supreme Court, and report its findings to the Board of Governors at the earliest possible date;
2. That pursuant to the recommendations of the Blue Ribbon Panel, meetings be requested with the Governor, the Florida Bar and legislative leadership to obtain a concensus regarding a petition to the Supreme Court in respect to the contingency fee system;
3. That consideration be given to the feasibility of attempting to have petitions signed during and prior to the November 6 General Election that would include those appropriate constitutional amendments as recommended by the Blue Ribbon Panel;
4. That every effort be made to obtain a commitment from the Governor and/or legislative leadership to place on the Agenda for the special November Session of the Legislature, a resolution of the professional liability crisis subject to the development of a proposed legislative program.

Included as Appendix C-2 to Report C of the Board is an historical review of the professional liability crisis, and a summary of the Association's past and current activities to resolve the crisis.

In addition, as your President, I have met with Governor Graham, the President of the Senate, the Speaker of the House of Representatives, Committee Chairmen Barron and Gustafson, Insurance Commissioner Bill Gunter, and representatives of the hospital association, the insurance industry, the business community, the American Association of Retired Persons, the Florida

Bar Association, and the Florida Academy of Trial Lawyers. I have appeared as a witness before the two task forces that have been studying the professional liability problem over the past several months.

The FMA's professional liability legislative program will be finalized following submission of the report and recommendations of the Governor's Task Force on Medical Malpractice. The provisions to the included in the FMA's tort reform package are outlined in Board Report D, The Council on Legislation, (pink — Reference Committee IV).

Florida Physicians' Insurance Reciprocal

On Monday, May 7, 1985, the State Insurance Commissioner of Florida, armed with a court order, gave the Florida Physicians' Insurance Reciprocal (FPIR) 30 days in which to show cause why it should not be placed into receivership. The Department's action was based on the results of a triennial examination of the FPIR that raised grave concerns that the FPIR had a serious deficiency in its surplus and was in jeopardy of not being able to discharge its liabilities.

The Department sought to disallow retroactively certain assets of the FPIR including:

- The Reciprocal's purchase of surplus relief when it has been an industry practice for many years, and;
- Investment in high return limited partnerships which had been approved previously in prineiple by the Department.

Disallowing these assets would cause the FPIR to fall short of the level of assets required by Florida law for a domestic insurance carrier. The FPIR had 30 days in whieh to reconcile these differences with the Insurance Commissioner. This action by the Department shocked the leadership of the FMA and those physicians who receive their professional liability protection through the FPIR.

Your Board of Governors aeted immediately to investigate the problems of the Reciprocal and began a strenuous effort to seek a solution that would assure physicians covered by FPIR continuity of professional liability protection with no lapse in coverage.

After over five months of intense effort, the FMA was successful in producing an ongoing physician-owned professional liability insurance program for FMA members. Insurance Commissioner Bill Gunter announced on October 19, that the Florida Physicians' Insurance Reciprocal plan for rehabilitation would be submitted to the Circuit Court in Tallahassee for approval on October 25. Under the plan, the Insurance Department would enter into a management contract with the Physicians Insurance Company of Ohio (PICO) to provide management for the FPIR until and after the completion of the rehabilitation phase on December 31, 1984.

The development of a successful rehabilitation plan for the FPIR was due to the cooperative efforts of the Insurance Commissioner and members of his staff, with FMA and PICO, and the many dedicated subscribers of the FPIR who felt it was important to continue our physician-owned professional liability insurance company.

In a hearing held January 3, 1985 in Tallahassee, Circuit Judge Charles E. Miner, Jr., terminated the rehabilitation of the Florida Physicians' Insurance Reciprocal and returned the company to its new management, the Physicians Insurance Company of Ohio (PICO). In terminating the rehabilitation, the Court found that the Receiver's Plan of Rehabilitation had been complied with, and the Reciprocal could be returned to its new management without further jeopardy to the insurer and its creditors, claimants, subscribers or to the public. The Board of Governors believes that the termination of the rehabilitation will remove the current cloud of uncertainty about the Reciprocal's future and will enhance the ability of the Reciprocal to gain subscribers and will assure the ability of the Reciprocal to regain its former position in the market as a financially sound and competently managed company. The FPIR will be coverted to a stock company at the earliest possible date in 1985. A report on the operations of the FPIR will be included in the Delegates' Notebook. (Appendix C-3).

The Board also reviewed in great depth the problems encountered by the Reciprocal and directed that a "Big Eight" national accounting firm be retained to conduct an in-depth review of the finances and operation of the company and report its findings to the Board at the earliest possible date, and further, that the findings of the review be reported to the FMA membership. This review was completed and mailed to the entire FMA membership on January 4, 1985.

Finance

Income / Expenditures, 1984: The Association had a total income of $3,233,608 during 1984 from all sources including the following:

Dues and fees	$2,685,593
FMA *Journal*	130,569
Directory and other publications	36,761
Technical Exhibits	10,100
Interest and Dividends	325,865
Special Services	21,526
Special Contracts	12,863
GTE/MINET Program	10,331
Total Income	$3,233,608

Total expenditures during the year were $3,532,344 in the following categories:

General Activities:	$1,111,356
Contract Services:	254,048
Administration:	678,694
Personnel:	1,472,736
Corporate Fund:	15,510
Total Expenditures:	$3,532,344

FMA Trust Fund: The House of Delegates in 1980, authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate past living presidents of the Association, including the Immediate Past President who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of $137,000 and, as directed by the Board, was placed in the reserve fund.

The first four annual principal payments on the mortgage held by the FMA on the 801 property of $286,394 were placed in this trust fund. The interest earned through December 31, 1984 in the fund was $118,070 and the total balance in the trust fund as of December 31, 1984, was $541,464.

1982 FMA Assessment: The House of Delegates in 1982 authorized, at the discretion of the Board, a $50.00 mandatory assessment of all FMA active members for professional liability.

The Board, at its meeting on August 8, 1982, determined the assessment was needed to carry out the Association's professional liability program. As of the date of this report, total funds collected have been $572,092 including interest earned of $24,340. Total amount of expenditures to date are $572,092.

1984 FMA Assessment: The House of Delegates at a special called meeting on January 28, 1984, unanimously approved a mandatory assessment of $300.00 for all regular active dues paying members of the FMA to be utilized for implementing the FMA professional liability program. The assessment was billed on March 12, 1984, to 11,673 active members for whom the assessment was mandatory and to 2,866 members in other classifications, who were invited to pay the assessment on a voluntary basis. As of the date of the report, 9,701 active members have paid the assessment for a total of $2,910,300. A total of 739 voluntary payments were received for a total of $217,910.

In compliance with actions of the House of Delegates, these funds have been utilized solely for the FMA professional liability program including The Reason '84 Constitutional Initiative Campaign. As of the date of this report $2,393,500 had been transferred to the Reason '84 account. The campaign received income from other sources as follows:

• Campaign donation from the AMA	$ 250,000
• Campaign advance of funds from AMA (repaid on March 29, 1985)	500,000
• Direct mail responses	167,840
• Other state medical associations	9,350
Total income / Reason '84	$3,320,690

Total expenditures for the campaign as of the date of this report totaled $3,319,357 leaving a balance of $1,333 in the Reason '84 account. The balance of funds in the assessment account was $279,926, and $1,333 in the Reason '84 account for a total balance of funds in the amount of $281,259. As of the date of this report, 1,560 FMA members had not paid the mandatory assessment for a total of $468,000. An updated report on the 1984 assessment will be included in the Delegates Notebook.

The Board has established May 9, 1985, as the final date for payment of the 1984 special assessment, and thereafter any member who has not paid will be dropped from the membership of the Florida Medical Association and his/her respective county medical society.

The Board reviewed the financial statements and proposed 1985 budget presented by the Treasurer and Executive Director. The Board approved the proposed budget for 1985 for the total anticipated income from all sources and expenditures in the amount of $3,372,500. In keeping with the policy established by the House of Delegates, $50.00 of each member's dues was budgeted to public relations and legislative activities.

The audit conducted by the Association's CPA firm of Harbeson, Beckerleg and Fletcher for the year ending December 31, 1984, is available for inspection by any member of the Association who may wish to review it.

Judicial Council

In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1985.

RECOMMENDATION NO. C-1

THAT THE HOUSE OF DELEGATES APPROVE THE NOMINATION OF O. FRANK AGEE, M.D., OF GAINESVILLE, FOR ELECTION TO AN ADDITIONAL FIVE-YEAR TERM ON THE JUDICIAL COUNCIL AS THE REPRESENTATIVE FOR DISTRICT A.

CMS and FMA Communications: The Board directed that every effort be made to improve communications with county medical society executives and to broaden their involvement in the activities of the Association.

Annual Conference of Executives: The Board authorized the FMA to sponsor an annual joint conference of the FMA Executives at a time and location to be determined, and that the Association pay for travel and lodging and expenses for all those executives who wish to attend.

Executive Director Advisory Committee: The Board authorized the Executive Director to appoint an advisory committee similar to that of the AMA to be comprised of five members including county medical society and state specialty group representation, and that membership on the committee be rotated as feasible to allow the broadest possible participation, and that this committee meet with the Executive Director at times of his descretion to provide input into the activities of the association and to discuss issues of concern to county medical societies and specialty groups.

AMA — GTE/MINET: The Board approved the recommendation that the FMA offer to provide component county medical societies and specialty groups with necessary equipment to have access to the AMA MINET Communications Network with the actual cost of the equipment to be reimbursed to the FMA either in the total amount or through monthly repayment, and further, that this equipment be made available to members of the Board of Governors during their time on the Board.

Resolution — Michael H. Lopez, Jr.: The Board expressed deep regret over the sudden and unexpected death of Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society, and adopted the following resolution:

Whereas, Mike Lopez met an untimely death on December 22, 1984; and

Whereas, Mike Lopez was a steadfast friend of organized medicine and to all physicians and physicians' families; and

Whereas, Mike Lopez worked untiringly for the Palm Beach County Medical Society making it one of the most respected and effective component medical societies; and

Whereas, Mike Lopez was a personal friend to many members of organized medicine; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to Mike for his many contributions to organized medicine, and send a report of this action to his family in an expression of our deepest condolence.

Champus Program: The Board endorsed Blue Cross and Blue Shield of Florida, Inc. in its efforts to be designated as Administrator of the Champus Program in Florida.

FMA Councils and Committees

JUDICIAL COUNCIL

Grievance Procedures: The Board directed that the current grievance procedures being utilized by the FMA Judicial Council and county medical society grievance committees be submitted to the House of Delegates at its May, 1985 meeting for reaffirmation. (Appendix C-4)

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Local Membership Development Committee: The Board requested all county medical societies to establish committees on membership and development with primary responsibility for membership recruitment and retention; and further, county medical societies are asked to consider appointing to these committees a medical staff representative from each hospital in their area, as well as women physicians and where appropriate, resident physicians and medical student members.

Invitation to Join Campaign: The Board authorized the FMA to participate in the American Medical Association "An Invitation to Join" program.

Women In Medicine Seminar: The Board approved a half day workshop on leadership training for women in medicine to be held in conjunction with the 1985 FMA Leadership Conference. This seminar was an overwhelming success and the Board has approved a similar program to be held as part of the 1986 FMA Leadership Conference.

Florida State Medical Association: The Board extended an invitation to the Florida State Medical Association to send an observer with Privilege of the Floor to future FMA Annual Meetings.

COMMITTEE ON BYLAWS

The Board of Governors authorized a total review of the FMA Bylaws to be carried out during the 1985-86 Association year.

RECOMMENDATION C-2

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR THE FOLLOWING CHANGE WITH RESPECT TO REFERENCE COMMITTEE COMPOSITION:

CHAPTER IV
HOUSE OF DELEGATES

Section 15. REFERENCE COMMITTEES

Item 2. REFERENCE COMMITTEE COMPOSITION.

Reference committees shall be appointed by the Speaker, in consultation with the President, from the members of the House of Delegates. Each committee shall consist of AT LEAST five members, of which THE MAJORITY shall constitute a quorum. These appointments shall be published in The Handbook for Members of the House of Delegates and shall be announced at the first session of the Annual Meeting of the House of Delegates. The Speaker shall designate one member of each reference committee as Chairman. Officers and members of the Board of Governors shall not serve on reference committees and the report of the Chairman of a Standing Committee or the Chairman of a Council shall not be referred to a reference committee of which he is a member.

This removes the restriction of the size of the reference committees.

(New language in Bylaws — ALL CAPS)

COMMITTEE ON PROGRAMS AND PRIORITIES

The Committee on Programs and Priorities was established by the Board of Governors for the purpose of advising the FMA Executive Committee, which serves as the Long-Range Planning Committee, regarding the future programs and priorities of the Association. The Committee was specifically charged with the responsibility of carefully reviewing the current programs and priorities of the Association to determine if they accurately reflect the best interests of the physicians of Florida and their patients, as well as the many complex issues facing medicine in Florida and the entire country.

The Committee held five regional meetings which were attended by its members and representatives of county medical societies in the geographic area. These meetings were held in Jacksonville, Pensacola, Orlando, Tampa and Miami.

Spirited discussion took place at each of the meetings, which indicated some dissatisfaction and frustration about many of the activities of the FMA. The Committee Report contained more than twenty recommendations, which were considered first by the Executive Committee and then by the Board of Governors.

The Board commended the Committee on Programs and Priorities for the outstanding manner in which they carried out their responsibilities and duties in respect to the Committee's report and recommendation.

RECOMMENDATION C-3

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING RECOMMENDATIONS OF THE COMMITTEE ON PROGRAMS AND PRIORITIES AS APPROVED BY THE BOARD OF GOVERNORS:

A. THAT THE FLORIDA MEDICAL ASSOCIATION BECOME MORE INVOLVED WITH MEDICAL EDUCATION AT ALL LEVELS FROM UNDERGRADUATE AND RESIDENCY TRAINING PROGRAMS, THROUGH CONTINUING MEDICAL EDUCATION FOR PRACTICING PHYSICIANS.

B. Item B was considered separately and not adopted by the House, and therefore was removed from Report C of the Board of Governors.

C. THAT THE FMA EXPAND ITS PUBLIC RELATIONS PROGRAM WITHIN THE FISCAL RESOURCES OF THE ASSOCIATION.

D. THAT THE FMA REAFFIRM THE GOALS PREVIOUSLY ADOPTED AT THE OCTOBER BOARD MEETING FOR THE COMMITTEE ON HEALTH MANPOWER AS FOLLOWS:

- **IDENTIFY THOSE ALLIED HEALTH GROUPS THAT ANTICIPATE EXPANDED ACTIVITIES THROUGH LEGISLATION OR REGULATORY MEANS.**
- **IF POSSIBLE, IDENTIFY THE GOALS OF EACH ALLIED HEALTH GROUP.**
- **DEVELOP AN ADEQUATE DATA BASE FOR USE BY FMA, THE STAFF, AND COUNCILS AND COMMITTEES FOR COMMUNICATING WITH ALLIED HEALTH GROUPS.**
- **DEVELOP A DATA BASE ON PHYSICIAN MANPOWER IN FLORIDA WITH IDENTIFICATION OF AREAS OF SHORTAGES AND WHAT STEPS ARE BEING TAKEN TO CORRECT THESE SHORTAGES.**
- **DEVELOP A ROSTER OF EXPERT WITNESSES WHO WILL BE AVAILABLE UPON SHORT NOTICE TO REPRESENT THE FMA AT LEGISLATIVE HEARINGS.**
- **COOPERATE WITH OTHER AGENCIES AND GROUPS TO REMOVE PROBLEMS WITH FOREIGN TRAINED HEALTH CARE PROFESSIONALS.**

E. THAT THE FMA ESTABLISH A MECHANISM TO ENHANCE LIAISON WITH VOLUNTARY HEALTH AGENCIES.

F. THAT A SINGLE COMMUNICATION BE DISTRIBUTED TO THE FMA MEMBERSHIP ON A MONTHLY BASIS IN LIEU OF THE FMA BRIEFS AND GRAY PAPER, SUBJECT TO EVALUATION OF EFFECTIVENESS IN ONE YEAR.

G. THAT FMA ACTIVELY PROMOTE THE INSTALLATION AND UTILIZATION OF THE GTE/MINET SYSTEM (COMPUTERIZED MEDICAL DATA BASES AND ELECTRONIC MAIL) WITH THE FMA FIELD OFFICES, COUNTY MEDICAL SOCIETIES AND SPECIALTY SOCIETIES WITH OFFICES.

H. THAT EACH YEAR AT THE FIRST SESSION OF THE ANNUAL MEETING OF THE HOUSE OF DELEGATES, THE TREASURER PROVIDE A WRITTEN REPORT ON THE ASSOCIATION'S FINANCES TO EACH MEMBER OF THE HOUSE OF DELEGATES, PRESENT A VERBAL EXPLANA-

TION OF THE REPORT, AND RESPOND TO QUESTIONS IN AN APPROPRIATE FORUM.

I. **REFERRED TO THE EXECUTIVE DIRECTOR FOR A REPORT BACK TO THE EXECUTIVE COMMITTEE ON THE FISCAL IMPACT OF THE RECOMMENDATION THAT THE FMA ESTABLISH A MEDICO-LEGAL HOT LINE TO ASSIST PHYSICIANS CONFRONTED WITH POTENTIAL MEDICAL-LEGAL DIFFICULTIES.** (See Board Report E [goldenrod], Reference Committee V, in the Delegates Handbook.)

J. **THAT THE FMA MOVE THE ANNUAL MEETING TO SEPTEMBER BY 1987 AND BEGINNING WITH THE 1986 ANNUAL MEETING, IF POSSIBLE, AND THAT A BUSINESS MEETING OF THE HOUSE OF DELEGATES BE HELD IN JANUARY OF 1986 OR 1987 IN ORDER TO FACILITATE THE TRANSITION TO THE SEPTEMBER ANNUAL MEETING. THE BOARD REFERRED BACK TO THE COMMITTEE FOR FURTHER STUDY IN CONSULTATION WITH THE COUNCIL ON SCIENTIFIC ACTIVITIES' RECOMMENDATIONS REGARDING THE FORMAT AND LENGTH OF THE ANNUAL MEETING.**

K. **THAT THE FMA ANNUAL MEETING FORMAT BE REDUCED FROM A FIVE-DAY PROGRAM (WEDNESDAY TO SUNDAY) TO A FOUR-DAY PROGRAM (THURSDAY TO SUNDAY).**

L. **THAT FMA CONTINUE ITS COOPERATIVE AND MUTUALLY ADVANTAGEOUS RELATIONSHIP WITH THE AUXILIARY, WHOSE ABILITY TO ASSIST IN THE AREA OF LEGISLATION, POLITICAL EDUCATION, CULTURAL, PHILANTHROPIC AND ANY OTHER MEANINGFUL ACTIVITY IS ESSENTIAL.**

M. **THAT FMA CONTINUE ITS EFFORTS TO COORDINATE THE LEGISLATIVE ACTIVITIES OF SPECIALTY SOCIETIES IN CONCERT WITH THE FMA LEGISLATIVE PROGRAM, SUBJECT TO THE UNDERSTANDING THAT THIS RECOMMENDATION IS BEING IMPLEMENTED THROUGH THE COUNCIL ON LEGISLATION.**

N. **THAT FMA OFFER TO PROVIDE FULL OR PART-TIME ADMINISTRATIVE SUPPORT, SUBJECT TO APPROPRIATE FINANCIAL ARRANGEMENTS, TO ALL SPECIALTY SOCIETIES REQUESTING SUCH, AND FURTHER, THAT THE FMA CHIEF EXECUTIVE OFFICER MEET REGULARLY WITH SPECIALTY GROUP STAFFS.**

O. **THAT THE HOUSE OF DELEGATES EXPRESSED STRONG SUPPORT AND APPROVAL FOR THE RECOMMENDATION THAT EACH SPECIALTY GROUP RECOGNIZED BY THE FMA HAVE A VOTING DELEGATE AND ALTERNATE DELEGATE IN THE FMA HOUSE OF DELEGATES, PROVIDED NO DELEGATE WOULD HAVE MORE THAN ONE VOTE, AND THAT EACH DELEGATE MUST BE A MEMBER OF THE FLORIDA MEDICAL ASSOCIATION, AND FURTHER, THAT THE APPROPRIATE AMENDMENT TO THE FMA BYLAWS BE ADOPTED TO REFLECT THIS ACTION:**

CHAPTER IV
HOUSE OF DELEGATES

Section 1. DESIGNATION AND COMPOSITION

The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies AND SPECIALTY SOCIETIES in accordance with the provisions of these Bylaws, one member of the Hospital Medical Staffs Council appointed in accordance with the provisions of these Bylaws, and the Speaker and Vice Speaker of the House.

Section 6. DETERMINATION OF DELEGATES

Each component society shall be entitled to select annually and to send to each meeting of the House of Delegates one delegate for every forty active members of the Association within that society, and one for any fraction over and above the last complete unit of forty, as shown on the Association's records on December 31 of the preceding calendar year, provided that each component society holding a charter from the Association should be entitled to at least one delegate.

The student members of a component medical society within whose jurisdiction a school or college of medicine is located shall be entitled to select annually one delegate. This delegate must be approved by the county medical society and will be in addition to those chosen to represent regular members as provided elsewhere in these Bylaws.

EACH SPECIALTY SOCIETY RECOGNIZED BY THE FMA SHALL BE ENTITLED TO SELECT ANNUALLY AND SEND TO EACH MEETING OF THE HOUSE OF DELEGATES ONE DELEGATE WHO SHALL BE ENTITLED TO ONE VOTE. NO DELEGATE MAY REPRESENT MORE THAN ONE ORGANIZATION ENTITLED TO REPRESENTATION IN THE HOUSE OF DELEGATES.

The House of Delegates shall be limited as nearly as possible to a maximum of 250 regularly elected members from county medical societies, and one student delegate from each component society in whose jurisdiction a college or school of medicine exists. The Board of Governors shall automatically determine the ratio of delegates to active members to accomplish this limit of the membership of the House.

The House of Delegates shall have the power to determine its own membership and may by three-fourths vote of those delegates present in official session refuse to seat any delegate or alternate delegate.

Section 12. ALTERNATE DELEGATES

Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve. EACH SPECIALTY ENTITLED TO HAVE A DELEGATE SHALL BE ENTITLED TO SELECT ONE ALTERNATE DELEGATE TO SERVE WITH ITS DELEGATE.

Each alternate not seated as a delegate at the Annual Meeting shall continue to serve as an alternate until the next Annual Meeting and for all interim or called meetings between Annual Meetings, unless the component society by certification of its President or Secretary duly designates a different alternate.

A qualified alternate delegate may be seated for a delegate who is unable to attend the Annual Meeting or any session of the House of Delegates. The component society may seat an alternate delegate for the delegate provided that the alternate delegate deposits with the Credentials Committee a certificate signed by the President or Secretary of the component society stating that the alternate has been properly selected to serve. An alternate who has been seated at any single session of the House of Delegates shall serve throughout that session and may not have his place taken by any other delegate or alternate provided further, that once an alternate has been seated for a delegate during any session of the House of Delegates, that alternate shall be the only alter-

nate thereafter eligible to serve for that particular delegate at subsequent sessions of the House of Delegates during the Annual Meeting.

P. APPROVED AS AMENDED THE RECOMMENDATION REGARDING THE COMPOSITION OF THE FMA BOARD OF GOVERNORS:

- **THAT FUTURE VACANCIES ON THE BOARD OF GOVERNORS FROM EACH MEDICAL DISTRICT BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF FOUR YEARS BEGINNING IN 1986.**
- **THAT THE OFFICE OF SECRETARY AND TREASURER NOT BE COMBINED.**
- **THAT A RESIDENT PHYSICIAN WHOSE RESIDENCY STATUS WILL NOT EXPIRE BEFORE COMPLETION OF THE ELECTED TERM BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF TWO YEARS AND THAT SUCH PHYSICIAN HAVE A VOTE ON THE BOARD.**
- **THAT A MEDICAL STUDENT BE APPOINTED TO THE BOARD BY THE PRESIDENT FOR A TERM OF TWO YEARS BEGINNING AT THE CONCLUSION OF THE CURRENT MEDICAL STUDENT TERM AND THAT THIS POSITION BE ROTATED CONSECUTIVELY AMONG THE THREE MEDICAL SCHOOLS, AND FURTHER, THAT THE POSITION HAVE A VOTE ON THE BOARD.**
- **THAT THE REMAINING COMPOSITION OF THE BOARD OF GOVERNORS, IN RESPECT TO THE AMA DELEGATE POSITION AND ADVISORY POSITIONS, REMAIN AS CURRENTLY PROVIDED FOR IN THE FMA BYLAWS.**
- **THAT THE AT LARGE POSITION OF THE BOARD OF GOVERNORS BE RETAINED AND APPOINTED BY THE PRESIDENT FOR A ONE-YEAR TERM.**

WITH THE ABOVE CHANGES, COMPOSITION OF THE FMA BOARD OF GOVERNORS WOULD BE: PRESIDENT; PRESIDENT-ELECT; VICE PRESIDENT; SECRETARY; TREASURER; TWO IMMEDIATE PAST-PRESIDENTS; ONE OF THE DELEGATES TO THE HOUSE OF DELEGATES TO THE AMA (APPOINTED BY THE PRESIDENT); ONE REPRESENTATIVE FROM EACH MEDICAL DISTRICT (ELECTIONS BEGINNING IN 1986); RESIDENT PHYSICIAN; MEDICAL STUDENT; AND AN AT LARGE APPOINTMENT BY THE PRESIDENT (ALL ADVISORY MEMBERS APPOINTED AS CURRENTLY PROVIDED IN THE BYLAWS); AND FURTHER THAT THE FOLLOWING AMENDMENT TO THE FMA BYLAWS BE ADOPTED TO REFLECT THESE ACTIONS:

CHAPTER V
ELECTIONS

Section 1. ELECTION AND TERM OF OFFICE

All officers shall be elected annually by the House of Delegates, and shall serve until their successors are elected and installed.

MEDICAL DISTRICT REPRESENTATIVES TO THE BOARD OF GOVERNORS SHALL BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF FOUR YEARS BEGINNING WITH DISTRICT A IN 1986; DISTRICT B IN 1987; DISTRICT C IN 1988 AND DISTRICT D IN 1989 AND THEREAFTER AS TERMS EXPIRE.

A RESIDENT PHYSICIAN SHALL BE ELECTED BY THE HOUSE OF DELEGATES TO SERVE AS A MEMBER OF THE BOARD OF GOVERNORS FOR A TERM OF TWO YEARS BEGINNING IN 1986 AND THEREAFTER EVERY TWO YEARS.

Section 2. ELIGIBILITY

Any active member in good standing is eligible for any office, ~~provided that he meets the provisions set forth in the Bylaws.~~ PROVIDED THAT ONLY RESIDENT MEMBERS IN GOOD STANDING AND WHOSE RESIDENCY STATUS WILL NOT EXPIRE BEFORE COMPLETION OF THE ELECTED TERM SHALL BE ELIGIBLE FOR THE RESIDENT POSITION ON THE BOARD OF GOVERNORS AND FURTHER PROVIDED THAT ANYONE SEEKING AN OFFICE OTHERWISE MEET THE PROVISIONS SET FORTH IN THE BYLAWS.

Section 4. NOMINATIONS

Nominations for officers AND MEMBERS OF THE BOARD OF GOVERNORS of the Association and delegates to the House of Delegates of the American Medical Association shall be made from the floor of the House of Delegates by a member of the House. All active members of the Association are eligible for nomination. Nominating and seconding speeches shall be limited to a maximum of two minutes.

Section 5. TIME AND PLACE

The election of officers and MEMBERS OF THE BOARD OF GOVERNORS of the Association and delegates to the House of Delegates of the American Medical Association shall be held during the final session of any meeting of the House of Delegates. Only seated delegates shall be eligible to vote.

CHAPTER VII
BOARD OF GOVERNORS

Section 1. COMPOSITION

The Board of Governors shall consist of the FOLLOWING MEMBERS WHO SHALL HAVE BEEN ELECTED BY THE HOUSE OF DELEGATES: President, President-Elect, Vice-President, Secretary, Treasurer, the two Immediate Past Presidents, ~~one of the delegates to the House of Delegates of the AMA (who shall be appointed by the President); and five members appointed by the President. The President shall appoint one member from each of the four medical districts with staggered terms; and thereafter they shall be appointed for four years as each term expires; he shall also appoint each year one member at large for a term of one year.~~ ONE REPRESENTATIVE FROM EACH MEDICAL DISTRICT, AND A RESIDENT PHYSICIAN. IN ADDITION TO THE ABOVE, THE BOARD OF GOVERNORS SHALL CONSIST OF THE FOLLOWING MEMBERS WHO SHALL BE APPOINTED BY THE PRESIDENT: A MEDICAL STUDENT FOR A TERM OF TWO YEARS, PROVIDED HIS POSITION SHALL BE ROTATED CONSECUTIVELY AMONG THE THREE FLORIDA MEDICAL SCHOOLS; AN AT LARGE MEMBER FOR A TERM OF ONE YEAR; ONE OF THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMA FOR A TERM OF ONE YEAR.

The President shall designate, with the approval of the Board, one member to serve as a Public Relations Officer.

The Board, at its descretion, may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Florida Department of Health and Rehabilitation Services, from the State Board of Medical Examiners, and from the Board of Directors of the Florida Physicians' Insurance Reciprocal, all of whom must be members of the Association.

The Speaker of the House of Delegates shall be an advisory member of the Board of Governors.

(~~Deleted language~~ — NEW LANGUAGE)

Report F
Supplement to Report C
of the
Board of Governors

Supplemental Report F of the Board of Governors was adopted.

Recommendation No. F-1 was adopted.

Report F
Supplement to Report C
of the
Board of Governors

Frank C. Coleman, M.D., Chairman

Committee on Membership and Discipline

In compliance with the FMA Bylaws, the Board of Governors considered nominations for terms expiring in 1985 on the Committee on Membership and Discipline.

RECOMMENDATION NO. F-1

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING NOMINATIONS FOR ELECTION TO THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE FOR THE TERMS INDICATED:

DISTRICT 1:	**RUFUS THAMES, M.D. (89)**
DISTRICT 2:	**HERBERT E. BROOKS, M.D. (89)**
DISTRICT 3:	**JOE C. EBBINGHOUSE, M.D. (89)**
DISTRICT 4:	**BRUCE R. WITTEN, M.D. (89)**
DISTRICT 5:	**JAMES E. QUINN, M.D. (89)**
DISTRICT 6:	**RANDALL JENKINS, M.D. (89)**
	SAMUEL L. RENFROE, M.D. (89)
DISTRICT 7:	**JEFF W. HARRIS, M.D. (89)**
DISTRICT 8:	**ROYCE HOBBY, M.D. (89)**
DISTRICT 9:	**BETTIE R. DRAKE, M.D. (89)**
DISTRICT 10:	**JAMES D. MORGAN, M.D. (89)**
DISTRICT 11:	**E.J. VANN, M.D. (89)**
	RICHARD N. BANEY, M.D. (89)
DISTRICT 12:	**REGINALD J. STAMBAUGH, M.D. (89)**
DISTRICT 13:	**MARTIN F. MIHM, M.D. (89)**
DISTRICT 14:	**JAMES F. SMITH, M.D. (89)**
DISTRICT 15:	**ROBERT J. BRENNAN, M.D. (89)**
DISTRICT 16:	**JOSE F. LANDA, M.D. (89)**
DISTRICT 17:	**MAURICE H. LASZLO, M.D. (89)**
DISTRICT 18:	**RICHARD M. FLEMING, M.D. (89)**
DISTRICT 19:	**LINDA A. MARRACCINI, M.D. (89)**

PROFESSIONAL LIABILITY

The following is a status report on tort reform proposals currently under consideration by the Florida House of Representatives and the Senate, and the FMA's position and activities relative to each of these proposals. Any late developments on the professional liability issue will be distributed to the House of Delegates in a Supplemental Report at the Annual Meeting.

Governor's Task Force

The Governor's Task Force has concluded its deliberations and presented its final report to the Governor. The key recommendation of the Task Force involves an arbitration proposal for claims resolution. The proposal essentially would establish a requirement whereby a defendant in a medical malpractice action would have 90 days from the date the complaint is filed, to choose either binding or non-binding arbitration. The binding arbitration provision would be triggered if the defendant elects to admit "financial responsibility." Both parties would be required to participate and the claim would be submitted to arbitration on the issue of damages. If the defendant does not accept financial responsibility, the parties then submit their dispute on the issues of liability, damages, apportionment of responsibility among defendants to non-binding arbitration. If any of the parties reject the arbitration decision, certain penalties would be assessed against the rejecting party if they fail to improve their position at the subsequent trial.

Other key provisions of the Task Force Report involve the following:

- Mandatory Professional Liability Insurance
- Encourage Risk Management programs
- Increased authority for the Department of Professional Regulation in respect to investigation and discipline of licensed physicians.

At this time no specific legislation has been introduced to embody all of the Task Force recommendations. However, it is anticipated that certain of the recommendations will be amended into bills that are currently moving through the House and Senate.

The Barron Proposal — A Contract Mechanism for Resolution of Medical Malpractice Disputes

Senator Dempsey Barron (D-Panama City) has introduced in the Senate his revised bill in respect to an alternative, non-tort system for resolution of medical malpractice claims, Senate Bill 1030. Thirteen other Senators have signed the bill as co-sponsors.

The basic elements of the legislation are to preserve the threshold issue (breach of standard care), but it is settled by a judge rather than a jury. It proposes that the case be approached as one in contract rather than in tort. But once the obligation to pay damages has been established this proposal is much more predictable and forthright than the current system.

First, the bill provides reimbursement for all necessary and customary medical expenses. It also provides for rehabilitation benefits. All of this is designed to heal the person who is injured and to minimize the effects of the medical incident.

If the medical incident causes disability that lasts more than seven days there are specified temporary benefits and specified permanent benefits that are objective and that can be calculated up front, because they are based on the earning history of the injured person. They relate directly to the economic loss resulting from the medical incident and are designed to replace everything that was lost.

In addition, there are impairment benefits that can be as high as $100,000. These benefits are based upon a determination of the degree of disability the permanent injury causes to the plaintiff.

Finally, if death results, there are specific, identifiable death benefits for those who were dependent upon the deceased. There is no provision in the bill for general or non economic damages.

The bill purports that a person who is the victim of a medical incident will be much better off under the proposal than under the present tort system. If the right to damages can be established, he won't have to roll the dice to see whether he is undercom-

pensated or overly compensated. He won't have to share his award with his attorney (attorney's fees are in addition to the award) and the benefits will be paid forthwith. Moreover, the benefits are designed to **fairly** compensate the injured person for the adverse effects of the incident for so long as those adverse effects persist.

FMA has been working with Senator Barron to refine the bill and address the technical problems. It is anticipated that this bill, along with a bill introduced by Senator Mattox Hair (D-Jacksonville), will be the key pieces of legislation dealing with malpractice moving through the Senate.

House Proposed Sub-Committee Bill (PCB) 85-2 by Representative Art Simon (D-Dade)

On April 4, 1985, Representative Art Simon introduced PCB 85-2 which has been termed the "Comprehensive Medical Malpractice Reform Act of 1985." The bill proposes reform in three areas:

a. Claims prevention;
b. Claims resolution; and
c. insurance.

The following is a summary of the bill as prepared by the Committee staff:

"The prevention reform imposes liability on hospitals and required them to monitor the quality of their medical staff. Increased HRS overview of risk prevention programs supplements this effort. The 90-day presuit screening process and limitations on attorneys' fees (contingent fee sliding scale) highlight the claims resolution reforms. The imposition of mandatory malpractice insurance and the premium caps established in the JUA are designed to discourage doctors from practicing outside their areas of insured expertise while providing guaranteed access to affordable malpractice insurance.

Major points include triggered review of negligent physicians, increased risk management requirements, imposition on hospitals of responsibility for medical staff negligence, creation of a guaranteed maximum medical malpractice insurance premium, requirement of mandatory financial responsibility for certain doctors, and establishment of methods for case settlement and arbitration. The purpose is to reduce the societal costs of medical malpractice."

The FMA has met with Rep. Simon and has had an opportunity to present its recommendations in respect to the bill to Rep. Simon's Subcommittee. The key FMA recommendations for revision are as follows:

1. In respect to the section of the bill dealing with alternative methods of payment of damage awards, we recommend that the threshold be reduced to $500,000 for all damages and that the court be required to enter a judgement ordering the damages for future losses to be paid by periodic payments upon the motion of either party subject to the award meeting the other requirements of the section.
2. We recommend that the Committee consider revising the section of the bill dealing with presuit screening period and offers for admission of liability to provide for the defendant to foreclose the claim by offering, within 90 days of the notice provision contained in the bill, to pay the claimant's net economic loss, consisting of medical expenses and wage loss, and in addition, the defendant will be required to pay the claimant's attorney a reasonable attorney's fee. The proposal would obligate the claimant to accept payment of the net economic loss in total satisfaction of his personal injury claim in all cases except those in which the defendant intentionally inflicted injury or in which an injury caused permanent total disability. We recommend that the provision include incentive to encourage a defendant to offer to pay for the claimant's net economic loss. In order to do this, we would recommend such necessary incentive include where the defendant who refuses to pay a claimant's net economic loss within the prescribed time period, would not be able to interpose any defense based upon the claimant's fault in the ensuing trial. We believe the provision could also provide that once the the claimant has established a prima facie case of the defendant's liability, the burden of persuasion would shift to the defendant. In addition, at the claimant's option, the case could be placed on an expedited trial calendar; and finally, the incentive could provide for an award of court costs and attorney fees to the successful claimant.
3. We recommend the section of the bill dealing with a modification of joint and several liability be revised to include the provisions contained in the bill submitted to Representative Sam Bell, i.e., House Bill 622, as that bill would be modified to medical malpractice actions. (Rep. Bell's bill abolishes the doctrine of joint and several liability.)
4. We recommend the section of the bill dealing with the liability of health care facilities for the negligent acts or admissions of their medical staff and personnel be stricken.
5. We recommend that the section of the bill dealing with the establishment of a special risk category, which includes a premium cap on rates paid by physicians, be stricken from the bill.
6. We recommend that the section of the bill dealing with engaging in unnecessary diagnostic testing and penalties provided therefore be stricken from the bill.
7. We recommend that the section of the bill dealing with financial responsibility for health care providers, i.e., mandatory insurance coverage of $1 million per claim with a $3 million aggregate be stricken from the bill and language substituted that would allow for hospitals to require professional liability insurance for those medical staff personnel who work in the hospital.
8. We recommend that the section of the bill dealing with the authority of the Board of Medical Examiners to require 50 hours of continuing medical education be amended to provide that this provision may be satisfied by enrollment in a similar program under the auspices of the American Medical Association and/or the Florida Medical Association.

Senate

FMA members have been requested to contact members of the Senate urging their support for SB 1030 (by Barron and others) which provides a contract mechanism for resolving medical malpractice claims through judicial hearing, as an alternative to the current inefficient tort system. (The principles in Senator Barron's bill are consistent with the concepts for tort reform approved by the Board of Governors at its January 1985 meeting as reported in Dr. Coleman's *President's Memo* dated March 27, 1985.)

House

FMA members have also been requested to contact members of the House of Representatives urging them to support changes to the House Sub-committee proposal that will provide relief to the geometric increases in and frequency of claims. Specifically, the current draft of the bill does not contain any limitations on noneconomic losses, an effective structured payout provision, not abolition of the doctrine of joint and several liability, all of which are essential in order to favorably impact on current cost of the system. (The FMA's recommended amendments to the proposed House Subcommittee bill would substantially bring it into conformity with the FMA's position for legislative tort reform.)

1984 House of Delegates Referrals

The Board reviewed the proceedings of the House of Delegates and items requiring additional study and/or action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council and committee reports as well as in this and other reports of the Board of Governors in the Delegates' Handbook.

RESOLUTION 84-11
Uniform Medicare Reimbursement Schedule
Capital Medical Society

The resolution below was not adopted by the House of Delegates but was referred to the Board of Governors for review:

RESOLVED, That the Florida Medical Association take all measures necessary to seek a uniform Medicare reimbursement schedule for the state of Florida, and insofar as possible, for the nation as a whole.

Policy of the AMA: The policy of the American Medical Association (AMA) is that any reimbursement program should be paid for on the basis of the usual, customary, and prevailing fees of physicians which vary by geographic location. The three most recent recommendations of the AMA in support of this policy are contained in the AMA proceedings: Council on Medical Service Report D-1983, Annual; Council on Medical Service Report B-1983, Interim; and Council on Medical Service Report A, June, 1984.

Florida Requirements: The four Medicare charge areas for the State of Florida are grouped by counties according to a methodology mandated by the Health Care Finance Administration (HCFA). The HCFA formula includes the historical physician charges for a locality and the customary, usual, and prevailing charges which vary not only in Florida but throughout the United States.

Congressional Activity: The Office of Technology Assessment (OTA) of the U.S. Congress is currently examining alternative Medicare reimbursement mechanisms, which include negotiated fees, prepaid capitation, in addition to the current customary, usual, and prevailing method. The OTA is scheduled to submit its findings in July to a reactor panel. The findings of the OTA and the recommendations of the reactor panel will then be submitted to Congress. The alternatives being examined do not necessarily entail a uniform system.

The FMA will closely monitor the activity and recommendations of the OTA and of the reactor panel and other Congressional activity on this subject. Current HCFA requirements, however, preclude Florida from altering the present arrangement for Medicare reimbursement in the state.

RESOLUTION 84-14
Florida Medical Association
Responsibility of Quality of Life Legislation
Volusia County Medical Society

The resolution below was not adopted by the House of Delegates but was referred to the Board of Governors.

RESOLVED, That the Florida Medical Association be instructed to utilize its political influence and become involved in legislation which indirectly, as well as directly, affects the quality of life for the people of the state of Florida.

Quality of Life Legislation: In response to this resolution, the FMA is specifically supporting three legislative proposals directed toward improving the quality of life for residents and visitors to Florida. They are: Alzheimer's Disease; Drinking Age; and Seat Belts. The Alzheimer's Disease legislation would create an advisory committee composed of seven members appointed by the Governor to make recommendations to the Department of Health and Rehabilitative Services (HRS). The proposed legislation currently under consideration by the Legislature would also create the Alzheimer's Disease Research Trust Fund and provides that HRS shall contract for three specialized model day care programs in the state. The Drinking Age bill would prohibit the consumption or possession of alcoholic beverages by anyone under the age of 21. Seat Belt legislation as proposed in one bill would require the operator of a private passenger motor vehicle to wear safety seat belts. Another bill would require all passengers to wear safety seat belts. Another bill would require all passengers in a private passenger motor vehicle to wear safety seat belts. Each of these legislative proposals aims to improve the quality of life by addressing the problems of Alzheimer's Disease victims and their families, by raising the drinking age to a more mature minimum age, and by ensuring that motor vehicle operators and their passengers are protected from the fatal or crippling effects of being in an accident without wearing a seat belt.

Community Outreach Program: The Board of Governors further approved of a recommendation submitted by the Council on Legislation aimed at improving the image of physicians as community leaders and thereby enhancing the FMA's ability to demonstrate concern about the health needs of all people through the development of Community Outreach Programs. This recommendation calls for the Board of Governors to approve the development of suggested community outreach programs to be implemented through county medical societies and hospital medical staffs as a means of creating a base for improving the communications for FMA activities. In approving this recommendation it was noted that in light of existing negative legislative and public attitudes towards organized medicine, it was felt by the Council on Legislation that the FMA should encourage physician members to be more involved in local community activities. A community outreach program should therefore be developed and coordinated through the leadership of the county medical societies and the chiefs of staff of hospitals. The positive public relations benefits generated from such an effort would substantially assist in building the base for enhancing the FMA's relationship with the Legislature.

RESOLUTION 84-4
Occupational Licenses
Dade County Medical Association

The resolution below was not adopted by the House of Delegates but referred to the Board of Governors for review.

RESOLVED, That the Florida Medical Association sponsor statewide legislation which would require all counties and municipalities in Florida to examine and validate a current and active state medical license before issuing a local occupational license to any physician who seeks to maintain an office for the practice of medicine.

Proposed Legislation on Occupational Licenses: The new Health Care and Insurance Committee of the Florida House of Representatives in its proposed Comprehensive Medical Reform Act of 1985 specifically provides for provisions that would meet the objectives of this resolution. The proposed committee bill would create Section 205.194, Florida Statutes, which stipulates that a local occupational license may not be granted without proof and presentation of a state license. The FMA will monitor this provision throughout the Legislative Session to assure that it is maintained as a requirement in the Health Care and Insurance Committee's proposal and other proposals as necessary.

The Speaker called the membership of Palm Beach County to escort Dr. Elizabeth Joan Barice to the podium to be presented with the Certificate of Merit as commendation for exceptional and outstanding service to the Association, to the medical profession, and to the public in accordance with the Principles of Medical Ethics.

Certificate of Merit

Elizabeth Joan Barice, M.D.

Whereas, Elizabeth Joan Barice, M.D., of Singer Island, Florida, has rendered exceptional service to the Florida Medical Association, to organized medicine and to the public; and

Whereas, This dedicated physician was born in Camden, New Jersey, on January 10, 1941, attended the University of Florida and University of Florida College of Medicine and was graduated from Stanford University College of Medicine with a Doctor of Medicine and from Harvard University School of Public Health with a Master of Public Health degree; and

Whereas, This eminent lady served her patients with devotion in Internal Medicine for many years in the area of public health and has continued to serve the public in many activities which have focused on public health issues; and

Whereas, Dr. Barice has spent nine years of her career in research projects in an effort to improve the quality and value of health care by researching such areas as pharmacology and kinetics; and

Whereas, This dedicated individual is a participant in civic affairs having served as a member of the Drug Abuse Committee and The Charles Chairello Kidney Foundation in New Jersey, on the Board of Directors of both the Comprehensive Alcohol Rehabilitation Program and Project Outbound in West Palm Beach and on various committees by appointment; and

Whereas, Dr. Barice was a Delegate to the Florida Medical Association and served on the Medical Advisory Committee to United States Representatives; and

Whereas, She has been seen and heard by a television audience of millions as she spoke out on the subject of health, alcoholism and drug addiction and has published a book entitled, *The Palm Beach Diet;* and



Dr. E. Joan Barice accepts the Certificate of Merit from House Speaker, Dr. James B. Perry.

Whereas, This able individual continues to serve her profession by serving on the Executive Committee of the Palm Beach County Medical Society and as an Advisory to the Crippled Children's Society; and

Whereas, Dr. Barice has given freely of her time and talents to the medical community and to the people of the state of Florida and the world, therefore be it

RESOLVED, That a certificate of Merit be presented to Elizabeth Joan Barice, M.D., as a token of the warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this exceptional lady.

RESOLUTION 85-1
Public Relations Programs
Duval County Medical Society

RESOLUTION 85-10
Educational Advertising Campaigns
Dade County Medical Association

The motion of the Reference Committee that Resolutions 85-1 and 85-10 be considered together and referred to the Board of Governors carried.

RESOLUTION 85-1

Public Relations Program

(Referred to Board of Governors)

Whereas, Surveys have shown that the image of organized medicine in the eyes of the general public is less than desirable; and

Whereas, The traditional patient-personal physician relationship is being eroded by the movement towards alternative health delivery systems; and

Whereas, The Reason '84 effort awakened public awareness of the physicians' plight because of PLI; and

Whereas, The Florida Medical Association has not implemented an effective organized long-range program of public relations and positive physician image building; therefore be it

RESOLVED, That the FMA immediately develop a long-range program of public relations and positive physician image building, which is adequately funded and professionally staffed; and be it further

RESOLVED, That each county medical society be encouraged to establish a local public relations committee; and be it further

RESOLVED, That said long-range program of public relations be established in coordination with local county medical societies in order to maximize available talent and resources.

RESOLUTION 85-10

Educational Advertising Campaigns

(Referred to Board of Governors)

Whereas, The vast majority of the FMA membership endorses the private practice of medicine; and

Whereas, The membership is fearful of the greatest health care delivery system in the world being torn apart; and

Whereas, This organization should be dedicated in its fight to protect the private practice of medicine; therefore be it

RESOLVED, That the FMA immediately implement a statewide educational advertising campaign promoting the private practice of medicine and that this campaign continue until the 1986 Annual Meeting; and be it further

RESOLVED, That if additional funds are needed, each member be assessed a fair and appropriate amount, or the Association dues structure be amended to allow for this campaign.

RESOLUTION 85-3
Ruth Balle Recognition
Broward County Medical Society

Resolution 85-3 was adopted.

RESOLUTION 85-3

Ruth Balle Recognition

Brevard County Medical Society

RESOLVED, That the Florida Medical Association pay an official tribute to this outstanding lady of medicine, Ruth Balle, who has served our profession with dignity, pride, ability, and tender loving care; and be it further

RESOLVED, That a copy of this resolution be delivered to Ruth, in the form of a certificate, and a copy be rendered to the Brevard County Medical Society office and it members.

RESOLUTION 85-7
Relocation of FMA Headquarters
Dade County Medical Association

The motion from the Floor that Resolution 85-7 be referred to the Board of Governors carried.

RESOLUTION 85-7

Relocation of FMA Headquarters

(Referred to Board of Governors)

Whereas, The FMA member population base continues to shift southward; and

Whereas, Travel to Jacksonville from the state's population centers is extremely difficult; and

Whereas, Nearly all committee and council meetings are now held in locations other than the staff headquarters in Jacksonville; therefore be it

RESOLVED, That a committee composed of equal representation from each FMA district be created to conduct a feasibility study regarding the relocation of the Association headquarters to a more accessible location; and be it further

RESOLVED, That said report be presented to the 1986 Meeting of the House of Delegates.

RESOLUTION 85-13
Committee on Membership and Discipline
Broward County Medical Association

Resolution 85-13 was not adopted.

RESOLUTION 85-14
Florida Physicians Association
Broward County Medical Association

The motion from the Reference Committee that Resolution 85-14 be referred to the Board of Governors carried.

RESOLUTION 85-14

Florida Physicians Association

(Referred to Board of Governors)

Whereas, The Florida Physicians Association was created by the House of Delegates, while they report to the Board of Governors, the only activity reported to date has been of funds collected and dispensed; and

Whereas, The initial intent was to advise of third party contracts, possible trade union activity, carrier intervention as well as governmental; and

Whereas, The Florida Physicians Association apparently has adequate funds to conduct workshops, apply to the National Labor Relations Board for recognition as bargaining agent for Florida physicians, and other related activity; therefore be it

RESOLVED, That the FMA Board of Governors request the Florida Physicians Association to initiate positive programs supporting the intent of the House of Delegates at the time of generation of the Florida Physicians Association.



Vice Speaker Dr. Guy T. Selander of Jacksonville addresses the House of Delegates.

RESOLUTION 85-15
Specialty Society Awards
Lee County Medical Society

Resolution 85-15 was adopted.

RESOLVED, That no specialty society awards or recognition may be presented at a meeting of the FMA House of Delegates.

RESOLUTION 85-21
Non-Payment of 1984 Assessment
Dade County Medical Association

Resolution 85-21 was adopted.

RESOLUTION 85-21
Non-Payment of 1984 Assessment

RESOLVED, That the Board of Governors be instructed that no members be dropped from the Florida Medical Association and its component medical societies for non-payment of the 1984 mandatory assessment for professional liability until January 1, 1986.

The Chairman thanked each member of her Reference Committee: James T. Cook III, M.D., John C. Moore, M.D., Virgil A. Ponzoli Jr., M.D., Robert H. Hux, M.D., Glenn S. Hooper, M.D., and the AMA Delegate Advisors: T. Byron Thames, M.D. and O. William Davenport, M.D.; Mr. Donald C. Jones, Executive Director; Mr. John E. Thrasher, General Counsel; Ms. Linda Flowers, Recorder; and FMA staff members for their support of the Committee and the many members of the Association who attended their meeting and presented testimony.

The motion of the Reference Committee that the report of Reference Committee No. III, Finance and Administration, be adopted as amended carried.



The Council on Scientific Activities and leadership from Florida's Colleges of Medicine meet annually at the Dean's Luncheon. Left to right: Pierre J. Bouis Jr., M.D., Chairman, Council on Scientific Activities; Orris O. Rollie, M.D., Chairman, Committee on Medical Education; R. G. Lacsamana, M.D., newly appointed Editor of *The Journal of the Florida Medical Association, Inc.;* Robert C. Fore, Ed.D., Associate Executive Director for Programs; Daniel B. Nunn, M.D., Editor of *The Journal of the Florida Medical Association, Inc.;* Bernard J. Fogel, M.D., Dean, University of Miami School of Medicine; Frank C. Coleman, M.D., President, Florida Medical Association; Andor I. Szentivanyi, M.D., Dean, University of South Florida College of Medicine; Luis M. Perez, M.D., President-Elect, Florida Medical Association; Louis C. Murray, M.D., Chairman, Council on Legislation; William B. Deal, M.D., Dean, University of Florida College of Medicine.

The Vice Speaker, Dr. Selander, opened the floor for nominations of officers and AMA Delegates and Alternates.

Speaker of the House
Vice President
Secretary
Treasurer
AMA Delegate Seat #1
AMA Alternate Seat #4
AMA Delegate Seat #6
AMA Alternate Seat #6
AMA Delegate Seat #7
AMA Delegate Seat #8
AMA Alternate Seat #8

The Vice Speaker received a motion from the floor to elect by acclamation candidates for Vice President, Secretary, Treasurer, Speaker of the House, AMA Delegate Seats 1, 6, 7, 8 and Alternate Seats 4, 6 and 8, all of whom are incumbents and unopposed. The motion carried unanimously and the following candidates were elected.

Speaker of the House — Guy T. Selander, M.D.
Vice President — James G. White, M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.
AMA Delegate Seat #1 — T. Byron Thames, M.D.
AMA Alternate Seat #4 — Eugene G. Peek Jr., M.D.
AMA Delegate Seat #6 — Charles J. Kahn, M.D.
AMA Alternate Seat #6 — O. William Davenport, M.D.
AMA Delegate Seat #7 — Joseph C. Von Thron, M.D.
AMA Delegate Seat #8 — Louis C. Murray, M.D.
AMA Alternate Seat #8 — J. Lee Dockery, M.D.

The new terms for Delegate Seats 1, 6, 7, 8 and Alternate Seats 4, 6 and 8 are for two years (January 1, 1986 to December 31, 1987).

Nominations

President-Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect. Dr. George P. Mesenger of Broward County nominated Dr. James B. Perry of Broward County. The nomination was seconded by Dr. Harold G. Norman of Dade County; Dr. Luis R. Guerrero of Palm Beach County; and Arnold L. Tanis of Broward County.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House. Duval County Medical Society nominated Dr. Guy T. Selander. The nomination was seconded by Dr. Rufus K. Broadaway of Dade County; Dr. Hector R. Mendez of Orange County; Dr. Paul A. Flaten of Broward County; Dr. Donald G. Nikolaus of Pinellas; Dr. William J. Romanos of Palm Beach County; Dr. Kenneth C. Kiehl of Sarasota County; Dr. Joseph E. Holland of Lake County; and the Seminole County Medical Society.

Vice Speaker

The floor was opened for nominations for the office of Vice Speaker. Dr. Ernest G. Sayfie of Broward County nominated Dr. Arthur L. Eberly of Broward County. The nomination was seconded by Dr. Charles A. Dunn of Dade County; Dr. Clyde M. Collins of Duval County; Dr. John N. Carlson of Sarasota County; Dr. Charles J. Kahn of Escambia County; Dr. Kay K. Hanley of Pinellas County; and Dr. Louis C. Murray of Orange County.

Dr. William J. Romanos Jr., of Palm Beach County nominated Dr. V.A. Marks for the office of Vice Speaker. The nomination was seconded by Dr. Virgil A. Ponzoli Jr., of Collier County; Dr. Howard W. Pettingill of Brevard County; Dr. Nanjunda Swamy of Columbia County; Dr. Fred S. Carter of Martin County; and Dr. David R. Arrowsmith of Okaloosa County.

Dr. James W. Walker announced that he withdrew his name as a candidate for AMA Alternate Seat #7.

AMA Alternate Seat #1

The Vice Speaker opened the nominations for AMA Alternate Seat #1. Dr. V.A. Marks of Palm Beach County nominated Dr. Daniel L. Seckinger of Dade County.

AMA Delegate Seat #4

Dr. Glenn S. Hooper of Hillsborough County nominated Dr. Frank C. Coleman of Hillsborough County. The nomination was seconded by Dr. Joseph H. Davis of Dade County and Dr. Ernest G. Sayfie of Broward County.

AMA Alternate Seat #3

Dr. William J. Romanos Jr., of Palm Beach County nominated Dr. Lee A. Fischer of Palm Beach County. The nomination was seconded by Dr. A. Fredrick Schild of Dade County and Dr. George T. Edwards of Broward County.

AMA Alternate Seat #7

Dr. Harold G. Norman nominated Dr. Charles A. Dunn of Dade County. The nomination was seconded by Luis R. Guerrero of Palm Beach County; Kenneth C. Kiehl of Sarasota County; and George T. Edwards of Broward County.

AMA Alternate Seat #9

Dr. Robert L. Dawson of Pinellas County nominated Dr. Kay K. Hanley of Pinellas County. The nomination was seconded by Dr. Ernest G. Sayfie of Broward County and Dr. A. Fredrick Schild of Dade County.

Judicial Council

The Speaker referred the House to the Report of the Board of Governors (Report F) in which the Board had nominated O. Frank Agee, M.D., of Gainesville to a five-year term expiring in 1990, on the Judicial Council as a representative from District A.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its supplemental Report F of the Board of Governors and advised the House that he would entertain any addtional nominations from the floor. The Speaker thereupon announced the names of the nominees for each district:

District 1:	Rufus Thames, M.D. (89)
District 2:	Herbert E. Brooks, M.D. (89)
District 3:	Joe C. Ebbinghouse, M.D. (89)
District 4:	Bruce R. Witten, M.D. (89)
District 5:	James E. Quinn, M.D. (89)
District 6:	Randall Jenkins, M.D. (89)
District 7:	Jeff W. Harris, M.D. (89)
District 8:	Royce Hobby, M.D. (89)
District 9:	Bettie R. Drake, M.D. (89)
District 10:	James D. Morgan, M.D. (89)
District 11:	E.J. Vann, M.D. (89)
District 12:	Reginald J. Stambaugh, M.D. (89)
District 13:	Martin F. Mihm, M.D. (89)
District 14:	James F. Smith, M.D. (89)
District 15:	Robert J. Brennan, M.D. (89)
District 16:	Jose F. Landa, M.D. (89)
District 17:	Maurice H. Laszlo, M.D. (89)
District 18:	Richard M. Fleming, M.D. (89)
District 19:	Linda A. Marraccini, M.D. (89)

The Speaker then announced that balloting would commence at 7:00 a.m. on Sunday prior to the opening session of the Third House of Delegates.

The meeting of the Second House of Delegates recessed at 5:45 p.m. to reconvene on Sunday, May 5, 1985, at 9:00 a.m.

Auxiliary Highlights



(1) Mrs. Milton (Jo) Tignor, President-Elect, and Mrs. V. A. (Susan) Marks, First Vice President (2) Displaying the Medi-File Card are Mrs. Barbara Castelli, Mrs. Bea George, and Mrs. Anne Swing (3) Mrs. Nancy Corwin (4) FMA-A President Mrs. Laurin G. (Nancy) Smith and President-Elect Mrs. Milton (Jo) Tignor (5) Dr. and Mrs. Milton Tignor (6) Dr. and Mrs. Laurin G. Smith (7) Dr. and Mrs. Laurin G. Smith and Dr. and Mrs. Milton F. Tignor













(8) Mrs. Nancy Smith and Mrs. Priscilla Gerber (9) Mrs. Marion Gilliland received the Auxiliary's Peggy Wilcox Award presented by Mrs. Edie Epstein (1) Mr. Douglas Kiker, FLAMPAC Speaker (11) Mrs. Nancy Smith presented Mrs. Jo Tignor with the FMA-A President's Pin (12) Mrs. Jo Tignor addresses the Auxiliary House of Delegates as the newly installed 85-86 FMA-A President (13) Mr. Douglas Kiker and Mrs. Jo Tignor at the Annual FLAMPAC Luncheon (14) FMA President-Elect Dr. Luis M. Perez and FMA-A President-Elect Mrs. Jo Tignor.


8


9


10


11


12


13


14

Third House of Delegates

The third meeting of the House of Delegates convened at 9:10 a.m. on Sunday, May 5, 1985, Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, James B. Perry, M.D., Speaker of the House presiding.

Dr. Richard I. Barr of the Credentials Committee reported that 193 delegates were registered, representing 36 county societies, which constitutes a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; Elayne E. Cassisi, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; Gerold L. Schiebler, M.D.; Michael Fagien, Student Delegate.

BAY — James T. Cook III, M.D.; (Absent — B. Phillip Cotton, M.D.; Terrence R. Steiner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Antonio Catasus, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.; (Absent — Onofre P. Carrillo, M.D.)

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Ernest G. Sayfie, M.D.; Marvin L. Stein, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — George J. Crane, M.D.; Arthur L. Eberly, M.D.; John M. Harper, M.D.; David C. Lane, M.D.; Joseph M. Sachs, M.D.; Richard D. Shafron, M.D.; Donald D. Sheffel, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.; (Absent — Jack W. MacDonald, M.D.)

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Clarence M. Harris, M.D.

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Nanjunda Swamy, M.D.

DADE — Jerome Benson, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Harlan S. Chiron, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Simon Frank, M.D.; Antonio F. Frexes, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Marraccini, M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; A. Fredrick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Charles F. Tate, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Edward R. Annis, M.D.; Virgilio I. Beato, M.D.; Pedro P. Bosch, M.D.; N. Ralph Frankel, M.D.; Sean M. Kaufman, M.D.; Horace A. Leyva, M.D.; Charles A. Monnin Jr., M.D.; Oscar Sandoval, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.: Jack L. Sapolsky, M.D.; Seabury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — Gaston J. Acosta-Rua, M.D.; William P. Booras, M.D.; Leif A. Lohrbauer, M.D.; Daniel B. Nunn, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — C. Fenner McConnell, M.D.)

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Greiwe, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas E. McKell, M..; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate)

INDIAN RIVER — Kip G. Kelso, M.D.; Michael B. Zimmer, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.; Stephen R. Zellner, M.D.; (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Roger A. Meyer, M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; (Absent — George E. McLain, M.D.)

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Wallace M. Philips Jr., M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Henry J. Baskin, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Robert N. Serros, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; George L. Ford Jr., M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Gilbert R. Panzer, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Robert Burger, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Vincent Cotroneo, M.D.; Carl W. Graves, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overby, M.D.; Bruce P. Smith, M.D.; (Absent — Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — Edward D. Risch, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; (Absent — David L. Fromang, M.D.; Manuel G. Garcia, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; Richard J. Beebe, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Ernest C. Smith Jr., M.D.; David L. Thomas, M.D.

SEMINOLE — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — Harry F. Farmer, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; (Absent — Martin S. Feigenbaum, M.D.)

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Dr. Perry then recognized President, Dr. Frank C. Coleman, and asked that he come forward to install the new President.

Dr. Coleman presented the personal gavel and the President's Plaque to Dr. Luis M. Perez, the new President of the Florida Medical Association, Inc.

Dr. Perez in turn presented Dr. Coleman with the Past President's Pin, the new Past President's green blazer and gold cufflinks which have the same emblem as the Past President's Pin.

Dr. Perez then asked Mrs. Coleman, escorted by Dr. Glenn S. Hooper and Dr. Robert G. Isbell, to come to the platform for presentation of Dr. Coleman's portrait.

Remarks — Luis M. Perez, M.D., President

In the life of every person there are events that produce a change of direction, and even though it may not be known at that moment, these events may change one's life.

In my life in particular, the events that directed my destiny are these: graduation from medical school; marriage a year later, and then moving to a foreign country with a new language and a different philosophy and psychology; the birth of my sons; the take over of my native country by a communist regime, making impossible my return; passing the basic sciences and the Board of Medical Examiners; the start of private practice; suffering a myocardial infarction and coding three times; being elected by the House of Delegates first as Alternate Delegate then Delegate to the AMA; being elected Secretary of the FMA and finally, last year, President-Elect.

Now, taking office as your President is the culmination of a dream and, I know, a new direction to my life.

I think that, subconsciously, I have been preparing myself for this all these years, but I assure you that this past year as President-Elect, following Dr. Coleman to meeting after meeting, has proven to be more intense and demanding than my Internship and Residency years put together.

I never had to work so hard as I did to keep up with someone as dynamic as this man, with his strong personality, and his never ending capacity for work. It has been a rewarding experience and I can only hope that I will give my President-Elect such an example.

I want to mention to you at this time those who truly have the burden of facing the biggest sacrifices; they will have to be very patient with me:

First my wife, always at my side and my best sounding board, who always has and always will put up with endless days and nights of solitude and anxiety during my travels to distant places, in inclement weather, in small airplanes — Dr. Maria Perez;

My children, who also suffered the absence of their father while I was pursuing our aims for the good of all physicians in Florida — Luis Martin Perez Jr., and Hector "Tico" Perez;

My associate, who for the last year has been holding our practice together while I was away and will continue to do so — Dr. Chester D. Miltenberger;

And the staff in my office, with whom you are going to talk over the telephone for the next 16 months — Mrs. Ann Brady, Mrs. Nat Bentley, and Mrs. Judy Walker.

I also want to recognize the doctors in Sanford and Seminole County Medical Society, who over all these years have encouraged me to pursue my desires, and have helped me by their understanding and by facilitating coverage all the times I have been out of town on FMA business.

Last year was a difficult year for the FMA. This year, I know very well, is not going to be a rose garden. It is going to require a constant effort from the ones who represent you at the local, state and national level, because the surmounting difficulties that lie ahead for the practice of medicine in general are many and uncertain.

At the state level, the professional liability insurance issue continues at the front burner with several bills and modifications of the PLI package already introduced. We are watching very closely every one of the moves in this direction. Some are only window dressings; we will expose them as such. Others are more radical and may even be productive. We will support them as intensely as possible.

We are not considering these bills from the emotional point of view. Every one of them is analyzed by our consultants, actuarians and attorneys to determine which ones are the really useful, to diminish the incidence of frivolous suits and reduce the insurance premiums and awards.

Accidents happen in medicine and errors are committed like in any other human activity, and those patients who have to live with the result of accidents or errors should be fairly compensated, but there has to be a method by which the maloccurrence in medical treatment can be separated from the errors and preventable accidents.

The issue of non-physicians providers, which keeps rising its ugly head, year after year, threatening the quality of medical care to the public of our state, and increasing the liability issue to the physicians in hospital staffs, the physicians that oversee these individuals and the hospitals themselves.

Some sense has to be brought to the Legislators who eventually have to realize how detrimental this deviation from quality in the practice of medicine can be to the people of the state.

The drug abuse problem in our youngsters and middle age population continues to be an increasing problem in our society with its logical consequences in health care for these individuals. We should address this problem and offer guidance and education.

The young physicians, fresh out of their residency, face a serious problem. Pressed by debts from Medical School and training years, come into a new environment with very little guidance in how to manage. They have to face offers by entrepreneurs who run a gamut of health services which are very tempting as a fast solution and without having the insight of what it means to their future, and they are lured into these types of organizations. We have to give guidance and orientation to the young physicians if we want to preserve the individuality and independence of the medical practice and we have decided we will do so.

The increasing problems of quality of care at HMOs, IPAs, PPOs, etc. and the overutilization and exploitation of the health insurance companies benefits and abuse to patients at some ambulatory clinics, the so-called emergency or surgical medical centers and a few individual practitioners who have to be controlled in some manner. The Florida Medical Association has a moral and ethical duty to find the way to do so.

At the national level, the spectrum of DRGs for physicians in hospital practices, with all the complications this is bound to bring, the freezes on Medicare with increases in deductibles that penalizes not only hospitals and physicians, but the elderly population which is forever increasing in our state. The cuts in educational and research funds with a terrible implication for the future physicians and the health of the nation in the long run. The emphasis of the federal government on economy, divorced from quality of care, with its logical consequences, will bring about patient suffering and increases in liability. These are but a few, certainly not all of the issues we will be facing.

What are we to do next? In which direction shall we go to curtail, or at least ameliorate this trend? What kind of guidance must we offer the physicians in Florida and to the public in general whose health and wellbeing is our outmost responsibility?

First, we are going to continue our efforts this year in the Legislation to affect the necessary changes in order to diminish the PLI problems and the situation with non-physician providers. At the same time we are going to start an agressive public education program guided by professional public relation individuals to enhance the image of the physician and the benefits of the private practice of medicine, emphasizing the quality of care and all the attempts to diminish it for purely unfounded economical reasons.

We are also going to continue building bridges and liason with other groups vitally interested in PLI and quality of care at an affordable price, to form a solid front with clear understanding of the direction we are going, since there is a possibility in 1986 that we will have to appeal again to the public with another Constitutional Amendment on the PLI issue.

At the national level, our delegation, more and more influential as we grow larger, and more experienced under the leadership of Dr. Charles Donegan and the National Legislative Committee of our Association with Dr. Louis Murray as Chairman, will coordinate with AMA efforts in emphasizing our views and how these policies affect our state and the nation in general.

The work ahead is not going to be easy.

The Executive Committee of your Association and the members of the Board will have the responsibility to keep the link of communications open with the local medical societies in their district, and with medical staffs in hospitals from the area they represent.

And I appeal to you all, the Delegates from our component medical societies, to keep abreast of the issues and utilize every staff meeting, specialty meeting and medical society meeting you attend to keep everyone informed of our activities and efforts.

There have been serious problems with communication in the past, not because we have not tried to communicate. You and I have had innumerable Presidential Memos last year, which kept us informed of each and every problem. In every issue of *The Journal*, the President's Message and news of all the activities of the Association, has been published, and still, when we visited several local medical societies, we have had to answer questions on basic issues clearly stated over and over again, because the average physician does not take a few minutes to read our communications.

This will be one of our principal goals. We have to educate our members to realize that this Association and the AMA are vital to their professional careers, and even though the practice of medicine will never be as it was ten years ago, we, and only we, can influence the direction in which it is going to go.

Recognizing this, we have to develop a tighter society, a unity of direction, a better knowledge of the issues and the political realities of our times. We must be ready to be counted, to offer imaginative and novel solutions to the problems that face us, altering, modifying, changing concepts in the minds of the public at large, and exposing the proposals of our adversaries who are working diligently at the Federal level with the purpose of creating a socialistic type of medical services throughout the nation. We must show those who try to maintain chaos and confusion among ourselves, that they cannot reap, in the courts of law, the benefits that create their wealth, at our expense and that of our patients. This is why the theme for this year is going to **Unity.**

We have to regroup, to take the offensive. For too many years we have been coping with problems as they have been presented



Luis M. Perez, M.D., FMA President-Elect, addresses the House of Delegates.

to us and we have been at the defensive, but later we have learned, we have observed the process, we have analyzed, one by one, our defeats, and we have learned. We have dissected layer by layer each one of the processes we have been entangled with, and we have learned, and will continue learning.

And now we know our weaknesses and our strengths. And now we know that if we close the ranks, if we produce the necessary Unity for our efforts to culminate, if we take the offensive instead of the defensive position, our efforts will fructify and our profession will remain one of honor and distinction, respected and admired by all, for the benefit of the health of the people of our state and an example to the Nation.

I hope that my ideas and strengths are added to and built upon daily by this confidence and a continued input with constructive criticism from each and every one of you — our Delegates and medicine's leaders.

I would like to acknowledge my wife, Peg, and our six adult offspring and friends who have put up with my time-consuming interest in FMA activities. They have been an inspiration and a source of strength which I continue to draw upon daily.

I have a great deal of appreciation for the Broward County Medical Association and its delegation without whose continuing support, advice and efforts I would not be standing here today. I know that their leadership and hope their entire membership became an integral part of this Association's goal of 100% participation in the Florida Medical Association and its FLAMPAC organization.

I also give honor, respect and a deep feeling of thanks to my partners Willis Dickens, Roger Schnell, Gerold Golberg, Harrish Thaker and Linda Brown. Their support, coverage and help have been outstanding and without restraint.

As a member of the Board and a listener to the problems of various county societies, I have come to realize that a multifaceted approach to our many problems is not only necessary but is vital to our survival and to our ability to represent fellow colleagues in the arena of existence in which we find ourselves today.

I see challenges in the future of medicine that will make the last few years' problems picayune by comparison. These will have to be tackled on a day-to-day basis and with the input of each and every member of this Association. Solutions will be forthcoming and seemingly insurmountable obstacles need to be overcome.

I have enjoyed working with our President and Board who have become close, personal friends. This friendship is honed in the attrition of battle by fights both won and lost in your behalf. I personally thank each and every one of you for your efforts, insight and dedication that have allowed us to conclude another successful year and I call upon all to continue your support and help. I personally, and the Association collectively, need this effort. And I thank you all for your help and diligent sacrifices. God bless you and your families.

Election Results

At this time the Vice Speaker, Dr. Selander, advised the members of the House of Delegates of the results of elections held for the office of President-Elect.

President-Elect

The Vice Speaker announced that Dr. James B. Perry had been elected President-Elect.

Acceptance Speech of President-Elect

It us with a great sense of apprehension and humility that I accept the office of President-Elect — that you have in your generosity and out-pouring of confidence, encouragement and vote allowed me to attain.



Dr. James B. Perry makes his acceptance speech for the office of President-Elect.

Vice President
Secretary
Treasurer
AMA Delegate Seat #1
AMA Alternate Seat #1
AMA Alternate Seat #3
AMA Delegate Seat #4
AMA Alternate Seat #4
AMA Delegate Seat #6
AMA Alternate Seat #6
AMA Delegate Seat #7
AMA Alternate Seat #7
AMA Delegate Seat #8
AMA Alternate Seat #8

Vice President — James G. White, M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.

AMA Delegate Seat #1 — T. Byron Thames, M.D.
AMA Alternate Seat #1 — Daniel Seckinger, M.D.
AMA Alternate Seat #3 — Lee Fischer, M.D.
AMA Delegate Seat #4 — Frank C. Coleman, M.D.
AMA Alternate Seat #4 — Eugene G. Peek Jr., M.D.
AMA Delegate Seat #6 — Charles J. Kahn, M.D.
AMA Alternate Seat #6 — O. William Davenport, M.D.
AMA Delegate Seat #7 — Joseph C. Von Thron, M.D.
AMA Alternate Seat #7 Charles Dunn, M.D.
AMA Delegate Seat #8 — Louis C. Murray, M.D.
AMA Alternate Seat #8 — J. Lee Dockery, M.D.
AMA Alternate Seat #9 — Kay K. Hanley, M.D.

The new terms for Delegate Seats 1, 4, 6, 7, and 8 and Alternate Seats 1, 3, 4, 6, 7 and 8 are for two year terms beginning January 1, 1986 and ending December 31, 1987. Alternate Seats 3 and 9 will complete the term expiring December 31, 1986.

The Speaker, Dr. Perry, advised the members of the House of Delegates of the results of elections held for the offices of Vice Speaker and Committee on Membership and Discipline Districts 6 and 11.

Vice Speaker

The Speaker announced that Dr. Arthur L. Eberly had been elected Vice Speaker. Dr. V.A. Marks congratulated Dr. Eberly and moved that the election be by unanimous consent of the House of Delegates. The motion carried.

Committee on Membership and Discipline

The Speaker announced the results of District 6 and 11.

District 1: Rufus Thames, M.D. (89)
District 2: Herbert E. Brooks, M.D. (89)
District 3: Joe C. Ebbinghouse, M.D. (89)
District 4: Bruce R. Witten, M.D. (89)
District 5: James E. Quinn, M.D. (89)
District 6: Randall Jenkins, M.D. (89)
District 7: Jeff W. Harris, M.D. (89)
District 8: Royce Hobby, M.D. (89)
District 9: Bettie R. Drake, M.D. (89)
District 10: James D. Morgan, M.D. (89)
District 11: E.J. Vann, M.D. (89)
District 12: Reginald J. Stambaugh, M.D. (89)
District 13: Martin F. Mihm, M.D. (89)
District 14: James F. Smith, M.D. (89)
District 15: Robert J. Brennan, M.D. (89)
District 16: Jose F. Landa, M.D. (89)
District 17: Maurice H. Laszlo, M.D. (89)
District 18: Richard M. Fleming, M.D. (89)
District 19: Linda A. Marraccini, M.D. (89)

Change of Command


1


2


3


4

One of the highlights of the Third Session of the House of Delegates was the installation of the new President Luis M. Perez, M.D., and recognition of the many contributions of Immediate Past President Frank C. Coleman, M.D. (1) Immediate Past President Frank C. Coleman, M.D., presents the President's Plaque to Luis M. Perez, M.D., the new President of the Florida Medical Association, Inc. (2) Frank C. Coleman, M.D., proudly receives the Past President's Coat and Pin from President Luis M. Perez (3) Outgoing President Coleman passes the gavel to President Perez (4) According to tradition, the large portrait of the President which has been hanging in the lobby of the FMA Headquarters Office for the past year is presented to the President's wife at the Annual Meeting. President Luis M. Perez, M.D., presents the portrait to Mrs. Frank C. (Ruth) Coleman.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Selander called the Chairman and members of Reference Committee IV, Legislation and Miscellaneous, to present their report.

Dr. Kenneth C. Kiehl, Chairman, and his Committee came forward to present the report of Reference Committee IV, Legislation and Miscellaneous.

The Committee expressed its desire to publicly commend Dr. Louis C. Murray for his outstanding work in his role as Chairman of the Council on Legislation. The Committee further recognized and commended Thomas P. Wood, M.D., Chairman of State Legislation; Mr. Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs; Mr. George S. Palmer Jr., Assistant Director, Legislative Affairs; Mr. Jim McCloy, Assistant Director, Legislative Affairs; Mrs. Lucy Mohs, Legislative Analyst; and to all other FMA Staff members who provided outstanding support of our legislative program. The Committee also recognized the contributions of all members of the Florida Medical Association who participated in FMA legislative activities during the past year.

Council on Legislation

The Report of the Council on Legislation was filed.

Council on Legislation

Louis C. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

This Committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this Committee have kept in close touch with their assigned senators and congressmen on the national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out the FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive program of visitations was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

- Support for legislation to prohibit the FTC from using its authority to preempt state laws relative to professional licensure or tasks professionals may perform.
- Opposition to proposals that mandate physician acceptance of Medicare assignment.
- Opposition to legislation concerning governmental intervention in the care and treatment of newborns with life-threatening congenital impairments.
- Opposition to the legalization of heroin to use for pain if cannot be managed with currently available medications.
- Opposition to the extension of chiropractic and optometric services to military and veteran programs.

The Ninety-ninth Congress promises to be increasingly active in federal health legislation. Among the key issues that will be considered that are of particular interest to the FMA are:

- Opposition to the expansion of the use of prospective payment and D.R.G. system to specifically include physicians.
- Oppose efforts to impose further regulations on the practices of physicians in the hospital setting.
- Establishment of a Federal Vaccine Injury Compensation Program to compensate individuals who suffer certain injuries caused by designated injuries.
- Monitor efforts to modify malpractice laws at the federal legislative level.
- Changes in the federal financing of medical education.
- Amendments to the PRO law relating to confidentiality, sanctions, appeals and reconsiderations, and conduct of review.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation

The Committee on State Legislation has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Seven formal meetings of the Committee have been held, along with informal conferences among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1985 session of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser, Jr., Deputy Executive Director, Legislation & Public Affairs. He has been materially assisted by Mrs. Lucy Mohs, Legislative Analyst, George S. Palmer, Jr., Assistant Director of Legislative Affairs, and Jim McCloy, Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity have been the FMA Field Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Linda Bass, R.N., head of the clinic, has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day Program.
3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.
4. Publications. A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed.
5. 1984 Legislative Accomplishments. During the 1984 Legislative session, there were more than 300 legislative proposals that required action by the Committee on State Legislation or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

Issues Opposed by the Florida Medical Association Which were Defeated in the 1984 Legislative Session

- Authorization for establishment of Exclusive Provider Organizations (EPO's) in Florida.
- Statutory authorization for certain pharmacists to prescribe certain drugs from a formulary which is developed by a joint committee of the pharmacy and medical boards. Third party reimbursement would cover the prescription of such drugs and the pharmacy board would determine educational requirements, if any, to be able to become a "health-care consultant" (SB 45/HB 104).
- A requirement for hospitals to grant staff privileges to nurse anesthetists. Privileges cannot be denied only because a person is a nurse (SB 386/HB 620).
- Increased regulation of basic office personnel taking x-rays. The 1984 Legislature did adopt a licensure law containing no problem areas for primary care or other physicians (CS/SB 242).
- Reenactment of the licensure law for lay midwives. While the current licensure law was not reenacted, the Legislature did adopt a "grandfather" clause for those currently licensed or enrolled in midwifery schools (CS/SB 231).
- A requirement for blood banks and hospitals to allow a person to donate blood only for a specific relative (HB 241).
- Mandated hospital staff privileges for psychologists, lay midwives and nurse practitioners (SB 277, SB 407, HB 565, HB 418).
- Mandated certification and statutory delineation of duties of medical assistants (SB 97).
- Mandatory second surgical opinions (HB 894).
- Non-denial of hospital staff privileges for physicians tied to hospital occupancy rates (SB 460).
- Creating new definition of "medical" to include services rendered by chiropractors for purposes of the School Health Services Act (SB 272/HB 325).
- Establishment of "peer review committees" operating under the Department of Professional Regulation that would review and handle complaints about physicians' fees.
- Removal of exemption of confidentiality of medical staff meeting records from the Open Records Law (Proposed Committee Bill/Judiciary Committee).
- Requirement for insurance companies to institute programs to reward policyholders for the discovery of errors or overcharges on hospital bills. Insurors would be required to provide a monetary award not to exceed $1,000 for such a discovery (HB 179).



Reference Committee IV (Legislation and Miscellaneous) was chaired by Kenneth C. Kiehl, M.D., of Sarasota. Left to right: AMA Delegate, Sanford A. Mullen, M.D., Jacksonville; E. Joan Barice, M.D., Singer Island; David R. Arrowsmith, M.D., Ft. Walton Beach; Arnold L. Tanis, M.D., Hollywood; Kenneth C. Kiehl, M.D., Chairman, Sarasota; Louis C. Murray, M.D., AMA Delegate (Standing), Orlando; Mrs. Diane Bowker (not pictured), Recorder; Charles A. Dunn, M.D., Miami; Samuel L. Renfroe, M.D., Ocala; and Thomas R. Busard, M.D., Bradenton.

— Removal of the exemption from the Open Records Law of complaints against regulated professionals (HB 1269).
— Authorization for professional licensing boards to approve foreign medical schools; provide for remedial education; allow foreign medical graduates to be physician assistants (HB 1267).
—A requirement for medical examiners to obtain written consent from next of kin of deceased prior to removal or corneal tissue for a transplant (HB 394).

Other Health Legislation Passed by the Legislature

— Rewrite of the radiologic technologist law which allows basic x-ray machine operator to be utilized in all physician offices.
— Reenactment of the lay midwifery law which allows currently licensed lay midwives to continue their practice while subsequent midwives must be certified nurse midwives.
— Legislation that allows any competent adult to make a written declaration directing the withholding of life-prolonging procedures in the event such person has a terminal medical condition (CS/HB 127).
— Legislation expanding the coverage for newborn children in health insurance policies to include the newborn child of a family member of the insured or subscriber (SB 682, HB 260).
— Authorization for the Department of Professional Regulation to take disciplinary action against a provider who advertises a free service and then charges for it (SB 515, HB 837).
— Clarifying legislation that provides for separation of the regulation of health maintenance organizations and pre-paid health clinics ("Quintas") (SB 342).
— Authorization for the Department of HRS to set standards for the licensure of freestanding birth centers. Requires the centers to only accept patients who anticipate a normal delivery and further requires consultation agreements with physicians who have hospital obstetrical privileges (SB 782).
— Prohibition of sale of human body parts for valuable consideration, which does not include costs associated with removal, storage, or transportation (CS/SB 143).
— Abolishment of local mental health boards and restructuring of community mental health programs to include alcohol and drug abuse services (SB 797).
— Revision of the child abuse law including creation of child protection teams and recognition for guardians ad litem. Extensive injunctive powers are authorized to protect an abused child (CS/HB 988).
— A State Athletic Commission is created to regulate professional boxing (HB 171).
— Development of a brochure detailing breast cancer treatment alternatives by the Florida Cancer Control and Research Advisory Board. Communication of such information is required for certain patients by physicians (CS/HB 279).
— Authorization for the Department of Professional Regulation to take action to stop unlicensed professional activities (CS/SB 356).
— Authority is granted to physical therapists to perform assessments upon the request of persons who may prescribe such services (SB 546).
— Amendments were made to the Emergency Medical Services Act to clarify authority and various definitions (CS/SB 529).
— The School Health Services Act was substantially revised to clearly delineate responsibilities for implementation and standard setting (CS/SB 529).
— Regulates members of the Armed Forces who are engaged in their licensed profession in the private sector for profit to meet the licensure requirements, including the payment of fees (HB 1006).
— Makes it unlawful for a person to withhold information in order to obtain a controlled substance or a prescription for same from a practitioner when that person has received a similar substance within the last 30 days. In addition, the bill makes it unlawful to possess a prescription form not completed and signed by the practitioner whose name is imprinted on the form (CS/SB 228).
— Establishes state regulation of respiratory therapists through certification or registration pursuant to an examination (CS/HB 775).
— Reenacts the Occupational Therapy Licensure Act with an expanded disciplinary section (CS/SB 151).
— Amends the Pharmacy Practice Act to create an impaired pharmacists program (CS/SB 365).
— Establishes licensure requirements for persons performing electrolysis and creates an advisory council under the State Board of Medical Examiners (CS/SB 210).
— Amends Psychological Services Practice Act to require approval of continuing education for providers, programs and courses. A new section permits certain psychologists to practice hypnosis (HB 1013).
— Reenacts the Speech-Language Pathology and Audiology Act (SB 219).
— Gives the Department of HRS authority to interpret, by rule, the American College of Surgeons standards for trauma centers (CS/SB 529).
— Classifies aggravated child abuse as an element of murder in the first degree and second degree (SB 72).
— Provides for the definition of "private" swimming pool and exempts such from inspections by DHRS (CS/HB 262).
— Reenacts Chapter 404, F.S., which provides for the regulation of radiation producing machines and materials (CS/SB 241).
— Creates a legal obligation on employers to inform employees of the presence of any toxic substance found on the Florida Sunshine List in their place of work (CS/HB 426).
— Amends the Patient's Rights section of the Nursing Home Licensure Act to require nursing homes to reserve, for up to 15 days for a single hospitalization, a patient's bed when such patient is a Medicaid patient (CS/HB 255).
— Appropriates $3.9 million for the state to provide health insurance coverage to persons retired prior to January 1, 1976 under a state administrated retirement system and to surviving spouses not covered by Social Security (CS/SB 943).
— Changes the Patient's Compensation Fund fiscal year from July 1 - June 30 to January 1 - December 31 and delays increases in entry level amounts for six months to comply with fiscal year changes (HB 871).

Issues Vetoed by Governor Bob Graham

Governor Bob Graham exercised his veto authority by withholding approval of these bills and a portion of the 1985-86 budget that passed the 1984 Legislative Session.

Dental Anesthesia Amendment (CS/HB 997 and CS/SB 341) — Contained an amendment that would have allowed dentists to administer non-dental anesthesia.

Mandatory Chiropractic Insurance Coverage (HB 475) — Mandatory insurance coverage for chiropractic services.

Chiropractic College Appropriation — $150,000 from the General Revenue Fund to establish a school of chiropractic in the state.

Major Objectives of the FMA for the 1985 Session of the Legislature

— Support for solutions for resolving the professional liability crisis that will achieve stability in respect to the current cost of professional liability insurance and will provide to patients who are truly injured in the medical system an opportunity to

be adequately and efficiently compensated for their injuries and, further, that the FMA support the following concepts as solutions that meet the criteria set out above:

Tort Modification Package

— Caps on awards
— Structured settlements
— Eliminate joint and several liability, or

Alternative resolution of malpractice disputes through any of the following, but not limited to:

— Modified "No-Fault" or "Worker Compensation" approach
— Arbitration
— Screening panels
— "Trip Insurance"
— Other effective alternatives that might be identified

General solutions that would be considered upon the approval of the concepts contained in either Category 1 or 2:

— Strengthening risk management programs
— Strengthening the ability of the Board of Medical Examiners to deal with incompetent physicians
— Consider the feasibility of mandatory insurance for physicians (This concept is linked specifically to the elimination of the doctrine joint and several liability.)

— Support for changing the burden of proof for medical negligence from "the greater weight of evidence", to "clear and convincing evidence", and that the FMA legal counsel and appropriate defense attorneys be requested to offer an opinion as to the extent of benefit this change would present.
— Request that the Florida Legislature and the Florida Supreme Court continue to critically review the contingency fee system and potential inequities therein in order to maximize patient compensation in instances of medical malpractice.
— Support the need for development of legislation to provide additional information that may be necessary for the State Board of Medical Examiners to carry out disciplinary provisions of the Medical Practice Act in the most efficient manner possible.

Other Legislative Objectives of the FMA for the 1985 Session of the Legislature

— Support recommended changes to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida.
— Support for the concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient.
— Support for the Clean Indoor Air Act that prohibits smoking in public places, except in designated smoking areas.
— Support for continued funding for the Community Hospital Education Act to assist in residency training for primary care physicians.
— Opposition to authorize "Self-Care Consultants" to prescribe drugs contained in a formula without examination and diagnosis by a physician.
— Opposition to a $150,000 appropriation to establish a school of chiropractic in Florida.
— Opposition to mandate all insurance policies to include payment for chiropractic services.
— Opposition to authorize optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye.
— Opposition to mandated hospital staff privileges for non-physicians.
— Opposition to exemptions being created in the Medical Practice Act that would bypass present licensure requirements.

Supplemental Reports Council on Legislation

Supplemental Report dated April 26, 1985, was filed and Supplemental Report dated April 30, 1985, was adopted.

Supplemental Report Council on Legislation

Louis C. Murray, M.D., Chairman
Dated April 26, 1985

This is to update the report of the Council on Legislation. This report reflects the status of legislation as of April 26, 1985.

1. **Professional Liability and Tort Reform Proposals:** Because of the frequent and rapidly changing status of legislation relating to professional liability and tort reform, Delegates will be provided with a detailed and current report on the variety of legislation being debated by the Florida Legislature. At the time of this writing the Senate and House are voting on the elements to be contained in each chambers' respective products.
2. **Key Issues Contained in FMA's 1985 Legislative Program:**

— Support for legislation changing the burden of proof in medical negligence from "the greater weight of evidence" to "clear and convincing evidence" (SB 485, HB 90). SB 485 is in Senate Commerce Committee. HB 90 is in House Health Care and Insurance Committee.
— Support recommended changes to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida (SB 1209, HB 1217). SB 1209 is in Senate Economic, Community and Consumer Affairs Committee. HB 1217 is in House Appropriations Committee.
— Support for the concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient (HB 1003). No Senate bill has been filed. HB 1003 is in House Health and Rehabilitative Services Committee.
— Support for the Clean Indoor Air Act that prohibits smoking in public places, except in designated smoking areas (SB 204, HB 281). SB 204 is in Senate Governmental Operations Committee. HB 281 passed as a Committee Substitute in House HRS Committee.
— Support for continued funding for the Community Hospital Education Act to assist in residency training for primary care physicians. This concept will be considered by the Senate and House Appropriations Committees.
— Opposition to authorize "Self-Care Consultants" to prescribe drugs contained in a formula without examination and diagnosis by a physician (SB 636, HB 392). SB 636 is in Senate Economic, Community and Consumer Affairs Committee. HB 392 has been placed on the House Calendar.
— Opposition to a $150,000 appropriation to establish a school of chiropractic in Florida. This will be considered by House and Senate Appropriations Committees.
— Opposition to mandate all insurance policies to include payment for chiropractic services (SB 248, HB 170). SB 248 is in Senate Commerce Committee. HB 170 is in House Health Care and Insurance Committee.
— Opposition to authorize optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye. No bill has been filed in either House.

— Opposition to mandated hospital staff privileges for non-physicians (SB 303, SB 304, HB 519, HB 639). SB 303 has been placed on the Senate Calendar. SB 304 has been placed on the Senate Calendar. HB 519 is in House HRS Committee. HB 639 is in House HRS Committee.
— Opposition to exemptions being created in the Medical Practice Act that would bypass present licensure requirements (SB 1162, HB 1132). SB 1162 is in Senate HRS Committee. HB 1132 is in House Regulatory Reform Committee.
— Support for the establishment of day care programs and memory disorder clinics for persons suffering from Alzheimer's Disease (SB 212, HB 77). SB 121 is in Senate Appropriations Committee. HB 77 is in House Appropriation Committee.
— Support for raising the drinking age to 21 (SB 1, HB 42, HB 54). SB 1 is in Senate Finance and Tax Committee. HB 42 is in House Regulated Industries and Licensing Committee. HB 54 is on the House Calendar.
— Support for legislation prohibiting a physician from prescribing certain hormones for musclebuilding or enhancement of athletic perfomance (SB 380, HB 33). SB 380 was substituted by HB 33. HB 33 has passed both Houses and ordered enrolled.
— Support for legislation closing a loophole in the child restraining law (HB 6). No Senate bill has been filed. HB 6 is in House Appropriations Committee.
— Support for legislation requiring use of seatbelts (SB 144, HB 37, HB 47, HB 70). SB 144 is on the Senate Calendar. HB 37, 47, 70 were combined as a Committee Substitute and is in House Appropriations Committee.
— Support for legislation enhancing enforcement of quality of care by Department of Health and Rehabilitative Services for Health Maintenance Organizations (SB 573, PCB 1). SB 573 is in Senate Commerce Committee. PCB 1 is in House Health Care and Insurance Committee.
— Oppositon to expansion of Certificate of Need to physcian offices (SB 929, PCB 85-03). SB 929 is in Senate HRS Committee. PCB 85-03 is in House Health Care and Insurance Committee.
— Opposition to legislation mandating insurance payment for services provided by nurse anesthetists, advanced registered nurse practitioners, and psychologists (SB 305, SB 836, HB 518, HB 868). SB 305 is in Senate Commerce Committee. SB 836 is in Senate Commerce Committee. HB 518 is in House Health Care and Insurance Committee. HB 868 is in House Health Care and Insurance Committee.
— Opposition to legislation authorizing use of pitocin to augment labor in birthing centers (HB 854). No bill has been filed in the Senate. HB 854 was defeated on the House floor.
— Oppositon to legislation requiring identification of designated recipient of donated blood (SB 586). SB 586 is in Senate HRS Committee. No bill has been filed in the House.
— Oppositon to legislation permitting dentists who complete anesthesia residency at a medical school to administer nondental anesthesia (SB 1045). SB 1045 is in Senate Economic, Community and Consumer Affairs Committee. No bill has been filed in the House.
— Opposition to legislation limiting contributions by political action committees (PACs) (SB 168). SB 168 is in Senate Rules Committee.
— Opposition to legislation reenacting licensure of laymidwives (SB 1220, HB 991). SB 1220 is in Senate HRS Committee. HB 991 is in House HRS committee.
— Opposition to legislation creating Exclusive Provider Organizations (EPOs). No bill has been filed in either House.
— Opposition to legislation increasing physicians license renewal fees to fund health care for the indigent (SB 328, HB 272). SB 328 has been withdrawn. HB 272 defeated in House HRS Committee.

3. **Additional Major Health Legislation Filed**

a. **Continuation of regulation of naturopathic physicians (SB 246, HB 535):** SB 246 is on the Senate Special Order Calendar. HB 535 passed the House and is in Senate Economic, Community, and Consumer Affairs Committee.
b. **Wrongful Birth (SAB 245, HB 207):** Provides no person is liable in civil damages for any act or omission that results in a person being born alive instead of being aborted. SB 245 is in Senate Judiciary-Civil Committee. HB 207 is in House Judiciary Committee.
c. **Physician Licensing (CS/SB 340, HB 973):** Authorizes the State Board of Medical Examiners to issue distinguished scholar certificate to a physician to teach at a medical school. CS/SB 340 passed the Senate and is in House messages. HB 973 is in House Appropriations.
d. **Health Advocate (SB 369, HB 391):** Creates a Health Advocate to represent the public in all matters relating to the providing of health services. SB 369 is in Senate HRS Committee. HB 391 is in House Health Care and Insurance Committee.
e. **Mandatory Professional Liability Insurance (SB 412, HB 23):** Requires a physician to maintain not less than $500,000 in coverage as a condition of licensure. SB 412 is in Senate Commerce Committee. HB 23 is in House Judiciary Committee.
f. **Joint and Several Liability (SB 414, HB 569):** Provides the amount of damages awarded a party shall be apportioned according to the degree of fault. SB 414 is in Senate Judiciary-Civil Committee. HB 569 is in House Judiciary Committee.
g. **Second Surgical Opinion (CS/SB 467, CS/HB 149):** Requires second opinions prior to elective surgery in the state health insurance plan. Bill was amended to conduct pilot study. CS/SB 467 is in Senate Rules and Calendar Committee. CS/HB 145 is on House Calendar.
h. **Surgeons' Performance Records (SB 580):** Requires each hospital to maintain surgical performance records on elective surgery as a condition of licensure. SB 580 is in Senate HRS Committee. No bill has been filed in House.
i. **Medicaid Bidding (SB 676, HB 402):** Authorizes the Department of Health and Rehabilitative Services to contract with hospitals for Medicaid inpatient and outpatient services through competitive bidding or negotiations. SB 676 is in Senate HRS Committee. HB 402 is in House HRS Committee.
j. **Attorneys' Fees (SB 738):** Provides a sliding scale of attorney's fees and provides for screening panels in medical malpractice cases. SB 738 is in Senate Commerce Committee. No bill has been filed in House.
k. **Health Maintenance Organizations (SB 800):** Requires health maintenance organizations to make available care from chiropractors, podiatrists, and osteopaths at an added premium. SB 800 is in Senate HRS Committee. No bill has been filed in House.
l. **Children's Health Insurance (SB 948, HB 1031):** Requires insurers to provide coverage for children's health supervision until age 21. SB 948 is in Senate Commerce Committee. HB 1031 is in House Health Care and Insurance Committee.
m. **Negligence Actions and Damages (SB 1030):** Establishes a workers' compensation — no fault approach to resolving malpractice claims — The "Barron Plan." SB 1030 is in Senate Commerce Committee. No bill has been filed in House.

n. **"Sunrise Act" for Unregulated Professions (SB 1029):** Creates the "Sunrise Act" of 1985 to establish criteria to be considered by the Legislature when considering enacting laws to regulate previously unregulated function. SB 1029 is in Senate Governmental Operations. No bill has been filed in House.

o. **Certificates of Need (SB 1074):** Repeals the certificate of need process. SB 1074 is in Senate HRS Committee. No bill has been filed in House.

p. **Negligence Actions and Damages (SB 1023):** Provides for periodic payments for future losses over $100,000. SB 1023 is in Senate Commerce Committee. No bill has been filed in House.

q. **Physicians Insurance (SB 1055):** Requires physicians to have proof of financial responsibility as a condition of licensing, abolishes joint and several liability, and requires permission of court to plead punitive damages. SB 1055 is in Senate Commerce Committee. No bill has been filed in House.

r. **Patient's Compensation Fund (SB 1082):** Increases coverage amounts, provides limits of coverage for providers other than hospitals shall be exclusive of fund entry level amounts up to $4 million, shall be inclusive of fund entry level amounts in excess of $1 million, and shall not exceed $1 million per claim; provides a limit of $2.5 million per claim for hospitals; requires that assessments be sufficient to cover expected claims. SB 1082 is in Senate Commerce. No bill has been filed in House.

s. **Civil Actions/Damages (SB 1109):** Provides at any time in a civil action for money damages, any party may serve on an adverse party a written offer to compromise and settle the action; provides for acceptance or rejection of offers and for protection of minors; provides that an offeror whose settlement was rejected shall be entitled to recover from the adverse party if the offer was more favorable than the final judgement; provides the court may award litigation expenses and prejudgment interest penalites. SB 1109 is in Senate Judiciary-Civil Committee. No bill has been filed in House.

t. **Sovereign Immunity (SB 1121):** Waives sovereign immunity for liability arising from a breach of contract; provides no governmental employee shall be held personally liable or named as a party defendant; provides no limit on recovery for damages for bodily injury, wrongful death, or property damage; provides governmental liability does not include punitive damages; requires claims to be filed within 2 years; provides for offers of settlement and non-jury trials provides for apportionment of damages and for joint and several liability; provides a sliding scale for attorney fees based on the amount of damages awarded; requires governments to be insured for not less than $100,000 per person and $200,000 per incident; provides for structured payments on awards over $500,000. SB 1121 is in Senate Governmental Operations Committee. No bill has been filed in House.

u. **Medical Malpractice (SB 1229):** Requires licensed health facilities to investigate medical negligence or mental or physical impairment which may affect patient care; requires the Board of Medical Examiners and the Board of Osteopathic Medical Examiners to investigate physicians with two or more claims for malpractice in a five year period; provides medical malpractice insurance or self-insurance policies shall include sections relating to cooperation of the insured and rights of the insurer to settle without the insured's consent; requires insurance companies to report information on all claims to the Department of Insurance; provides the Department of Insurance shall notify the appropriate licensing board in the Department of Professional Regulation if it seems there are grounds for disciplinary action against a medical practioner; provides for periodic payments for future damages; provides for settlement offers of admission of liability and for arbitration. SB 1229 is in Senate Commerce Committee. No bill has been filed in House.

v. **Medical Review Panels (HB 348):** Establishes a medical review panel to hear claims before they may be filed in court. No bill has been filed in Senate. HB 348 is in House Health Care and Insurance Committee.

w. **Attorney Fees (HB 1176):** Requires the court to liberally construe the law which provides for attorney's fees to the prevailing party when the court finds there was an absence of a justifiable issue of law or fact. No bill has been filed in Senate. HB 1176 passes the House and is in Senate Messages.

x. **Settlement Offers (HB 1267):** Provides that at any time more than 30 days before a trial begins any party may make an offer to settle a claim for money or property in a civil case; provides an offer not accepted within 30 days is deemed withdrawn; provides that if the final judgement is not more favorable than the unaccepted offer, the one turning down the offer must pay costs and expenses incurred by the offeror after the making of the offer. No bill has been filed in Senate. HB 1267 is on the House Calendar.

y. **Foreign Doctors (HB 1323):** Provides graduates of foreign medical schools whose supervised clinical training was completed prior to November 28, 1984, and who apply for licensure before August 15, 1985, are exempt from the supervised clincial training requirements established by the Board of Medical Examiners. No bill has been filed in Senate. HB 1323 is on the House Calendar.

The Council on Legislation asks for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 26 and the time of the FMA Annual Meeting.

Supplemental Report
Council on Legislation
Louis C. Murray, M.D., Chairman
Dated April 30, 1985

This is to update the Report and Supplemental Report (April 26, 1985) of the Council on Legislation. This report reflects the status of professional liability legislation as of April 30, 1985.

1. **House Medical Malpractice Reform Bill (HB 1352):** Current Status — Reported favorably by House Health Care and Insurance Committee on April 29, 1985 to House Appropriations and Finance and Tax Committees, with Floor action scheduled for the week of May 6th. Summary — Major points include triggered review of negligent physicians; increased risk management requirements; imposition on hospitals of responsibility for medical staff negligence; the creation of a special risk category within the Florida Medical Malpractice Joint Underwriting Association providing for a guaranteed maximum medical malpractice insurance premium; requirement for mandatory insurance; a 90 day presuit screening process; limitations on contingent attorney fees.

2. **The Major Provisions of the Bill:**

 a. Make it mandatory for governing boards to investigate and determine whether good cause for discipline exists. If good cause is found to exist, the boards are required to

take some disciplinary action. The definition of "good cause" is also amended to include medical malpractice involving negligent conduct. The bill provides the Board or review committee with immunity from liability for any action taken without intentional fraud. The bill also extends such immunity to investigators, witnesses, or other persons carrying out the provisions of this disciplinary section.

b. Include a list of grounds for disciplinary action against a physician which may be taken by the Board of Medical Examiners. Presently, it is grounds for discipline if there is "gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances." The bill specifies that "repeated malpractice" includes, but is not limited to, having two or more claims for malpractice within the previous 5-year period resulting in a judgment or monetary settlement exceeding $10,000 and where each case involved negligent conduct. The bill requires the Board to investigate and determine if disciplinary action is warranted upon being notified by the Department of Insurance of a physician's having two or more paid claims (judgment or monetary settlement).

c. The bill expands the civil immunity provided to members of a medical review committee of a health care facility or professional society for acts performed within the scope of the functions of the committee. The immunity is not provided if the member acts with intentional fraud. The bill also extends this immunity to any person acting within the scope of the committee, including witnesses, reporters, and investigators. The immunity is further extended to persons acting within the scope of the functions of a peer review committee of an insurer. Health care facilities have a duty to review medical staff's competence. Health care providers must cooperate with the review. Medical malpractice liability is not affected. Penalties and restrictions on persons bringing suits against review committees are imposed.

d. Standards for medical negligence are rewritten in terms of the prevailing professional norm as opposed to the existing "accepted standard of care." Qualifications for medical experts are tightened to require practice or teaching within 5 years before the incident. Failure to order medical diagnostic testing is not actionable if carried out in good faith and with due regard for the standard of care.

e. In medical malpractice cases, certification by a plaintiff's attorney that a reasonable investigation of the case has been conducted is required by the proposed bill. This may be based on a written medical expert opinion. Claims for punitive damages may not be pled initially, but only with the permission of the court after an evidentiary showing of a reasonable grounds for the claim. These provisions are intended to discourage unfounded suits and spurious claims for punitive damages.

f. In any medical malpractice action in which the trier of fact makes an award for future damages which exceeds $500,000, the parties would be given the option of periodic payments.

g. Ninety days prior to filing a malpractice claim, a claimant would be required to file a notice of intent to initiate litigation. The defendant's insurer would be required to conduct a peer review process during this 90-day period. At the end of this presuit screening period the insurer may (1) reject the claim, (2) make a settlement offer, or (3) make an admission of liability and an offer to arbitrate the damages. A prospective defendant may make this third response contingent on a limitation of general damages. Claimant's counsel is required to give the claimant a formal opinion letter regarding any response. If a settlement offer is made and accepted within 90 days, the claimant's attorney fees are limited to 15 percent of the settlement. If offer (3) is made, the plaintiff may reject it and file suit. If the plaintiff accepts it, the parties go to arbitration and the arbitration award is binding. The intended purpose of this section is to encourage prompt settlement of meritorious claims.

h. A schedule of attorney contingent fees is established by the bill. The schedule will take effect on April 1, 1986 unless the Supreme Court of Florida adopts guidelines for the regulation of contingent fees. The schedule ranges from 15 percent to 45 percent and increases as the case moves through the various steps of the litigation process. For those amounts of a recovery in excess of $2 million, the maximum fee is 15 percent.

i. The powers of the trial court to review jury awards for excessiveness and inadequacy are extended. The current limitation of "clearly" excessive or inadequate is deleted. Trial courts are required to closely scrutinize awards for general damages exceeding $250,000 and those less than $5,000. General damages must bear a reasonable relation to the injury. On appeal, the trial court's action is not reversible if supported by substantial, competent evidence.

j. The bill provides that hospitals shall be vicariously liable for negligent acts of its staff, except for acts or omissions related to non-invasive diagnosis.

k. A special risk category is established for high risk doctors with a premium cap of the greater of $5,000 or 15 percent of the doctor's gross income. The deficit created by this cap is initially funded through a 10 percent premium surcharge on medical malpractice insurance premium. The remaining deficit is recovered from the medical malpractice insurers. Any additional deficits are to be collected from insurers who are members of the Florida Medical Malpractice JUA.

l. The bill requires financial responsibility (escrow or insurance) for physicians. The requirement will be phased in over three years.
$500,000 ($750,000 aggregate)/ Oct. 1, 1985-Sept. 30, 1986; $750,000 ($2.2 million aggregate)/Oct 1, 1986-Sept. 30, 1987; thereafter $1 million ($3 million aggregate).

m. The proposal calls for mandatory CME in the amount of a minimum of 60 hours every two years of which six hours is in risk management. Criteria and content of CME courses shall be approved by the Board of Medical Examiners. The Board may consider equivalent national or state educational courses to fulfill part or all of the requirement.

n. The bill establishes certain minimum standards for optional arbitration provisions in certain group HMO/PPO insurance contracts.

The bill presently does not include provisions dealing with the abolition of joint and several liability or limitations on general damages.

3. **Senate Action on Tort Reform/Medical Malpractice (SB 1055, SB 1232):** On Monday, April 29, the Senate Commerce Committee adopted two key bills that should soon go to the Senate floor:
SB 1055. This bill:
 a. Abolishes the Doctrine of Joint and Several Liability.
 b. Requires hearing before a judge prior to pleading for punitive damages.
 c. Requires professional liability insurance in amount of $250,000/$750,000 for all M.D.s and osteopaths.

SB 1232. This bill contains provisions revising the procedures for certification of foreign health care education institutions, mandatory continuing medical education of 30 hours every two years, and repeal of the statute on recovery of attorney fees ("loser pays"). In the committee, the following amendments were added and incorporated into CS/SB 1232:

a. Authorization for sale of professional liability insurance on a group basis to associations and organizations.
b. Clarification of constitutional issue in Informed Consent Law.
c. Improves remittitur and additur provision by removing "clearly" from criteria for determination of excessive or inadequate awards.
d. Prohibits insurance contracts from giving insured veto power over offeres, and requires 60 days notice before cancellation of a contract.
e. Allows insurer to require membership in a state or local society which maintains a medical review committee.
f. Sets up non-binding arbitration system to replace mediation panels. Contains penalties for refusal of decision if later court award varies from arbitration recommendation by more than 25 percent.

There hav been several other bills filed relating to the issue of professional liability, but none have received committee action to date.

The motion that the House of Delegates go on record to actively oppose and work to defeat mandatory malpractice insurance tied to licensure and that if the Legislature mandates malpractice insurance that the Board of Governors consider authorizing legal counsel to immediately test the law's constitutionality, carried.

Report D of the Board of Governors

The motion of the Reference Committee that Report D of the Board of Governors be adopted as corrected carried.

Report D of the Board of Governors

Frank C. Coleman, M.D., Chairman

Board Actions of Major Importance

The Annual Reports on the major activities of FLAMPAC and the Council on Legislation are included in this section of the Delegates' Handbook. The Board has carefully reviewed the activities of FLAMPAC and the Council during the past Association year and the Council's recommendations regarding important legislative issues to be addressed during the 1985 Session of the Florida Legislature. The Board submits the following report and/or recommendations to the House regarding each of the items addressed by FLAMPAC and the Council on Legislation.

FLAMPAC

Membership: The Board expressed commendations to FLAMPAC for the significant improvements achieved in the number of physicians and their spouses joining FLAMPAC as sustaining. The Board also noted that FLAMPAC was on the winning side in a large number of races during the 1984 elections and that an increasing number of physicians and their spouses had participated directly as volunteers in many of the campaigns.

FLAMPAC Board of Directors: In accordance with the FLAMPAC Bylaws, the Board of Governors approved appointments to the FLAMPAC Board of Directors for 1985 as reflected in the Report of FLAMPAC, Reference Committee III, blue, in the Delegates' Handbook, plus the following additional appointments to fill current vacancies:

Florida Congressional District 8	James L. West, M.D.
Florida Congressional District 11	Brian A. Gibbons, M.D.
Florida Congressional District 15	T. W. Hahn, M.D.
Member from the State At Large	Richard S. Hodes, M.D.
Member from FMA Auxiliary	Mrs. Donald G. Nikolaus

COUNCIL ON LEGISLATION

1984 Legislative Session: The Board received an extensive report on the actions taken on major health issues by the 1984 Legislature. It was noted that the 1984 Session again presented a significant challenge, both from the number of anti-medicine issues as well as the disappointment of the complete failure of the Legislature to address the professional liability issue. A complete report on health issues acted on by the Legislature is summarized in the Annual Report of the Council on Legislation included in the Delegates' Handbook.

1985 Legislative Session: The following is a summary of the FMA legislative priorities approved by the Board for the 1985 Session. Additional items and information on legislative issues affecting physicians and health care are included in the Report of the Council on Legislation in the Delegates' Handbook or will be included in a Supplemental Report of the Council which will be distributed to Delegates at the Annual Meeting.

Professional Liability: The Board of Governors and the FMA House of Delegates at its special Called Meeting on January 28, 1984, reaffirmed professional liability as a major legislative priority. Bills were introduced in the House and Senate for consideration by the 1984 Legislature which embody the same proposals as those approved by the House of Delegates for the constitutional initiative campaign including:

- Summary judgments;
- Limitations on noneconomic damages;
- Elimination of joint and several liability.

The support in the Senate for the FMA's tort reform proposals was overwhelming, as it was during the 1983 session. Unfortunately the Speaker of the House, a trial lawyer, once again, as he did in 1983, refused to even allow debate on the professional liability issue. As a result, nothing happened during the 1984 session, and the FMA was forced to take the professional liability problem to the citizens of Florida through the constitutional initiative process. A complete report on the Reason '84 Constitutional Initiative Campaign and the continuing activities of the FMA in seeking lasting and effective solutions to the professional liability crisis in our state is included in Board Report C in the Delegates' Handbook. Resolution of the professional liability dilemma will remain the number one legislative priority of the FMA during the 1985 session.

The Board directed that following completion of the report of the Governor's Task Force on Medical Malpractice that FMA introduce, during the 1985 Session of the Florida Legislature, legisla-

tion which embodies those concepts for tort reform through the legislative process or other remedial actions as approved by the Board of Governors at its meeting in January 1985 including a concept for a limitation on general (noneconomic) damages:

THAT THE FMA BOARD OF GOVERNORS APPROVE SUPPORT OF SOLUTIONS FOR RESOLVING THE PROFESSIONAL LIABILITY THAT WILL ACHIEVE STABILITY IN RESPECT TO THE CURRENT COST OF PROFESSIONAL LIABILITY INSURANCE AND WILL PROVIDE TO PATIENTS WHO ARE TRULY INJURED IN THE MEDICAL SYSTEM AN OPPORTUNITY TO BE ADEQUATELY ^ND EFFICIENTLY COMPENSATED FOR THEIR INJURIES; AND FURTHER, THAT THE FMA SUPPORT THE FOOLLOWING CONCEPT A SOLUTIONS THAT MEET THE CRITERIA SET OUT ABOVE:

1. TORT MODIFICATION PACKAGE
 A. CAPS ON AWARDS
 B. STRUCTURED SETTLEMENTS
 C. ELIMINAT JOINT AND SEVERAL LIABILITY, OR
2. ALTERNATIVE RESOLUTION FOR MALPRACTICE DISPUTES THROUGH ANY OF THE FOLLOWING, BUT NOT LIMITED TO:
 A. MODIFIED "NO-FAULT" OR "WORKER COMPENSATION" APPROACH
 B. ARBITRATION
 C. SCREENING PANELS
 D. "TRIP INSURANCE"
 E. OTHER EFFECTIVE ALTERNATIVES THAT MIGHT BE IDENTIFIED
3. ADDITIONAL CONSIDERATIONS:
 A. STRENGTHENING RISK MANAGEMENT PROGRAMS
 B. STRENGTHENING THE ABILITY OF THE BOARD OF MEDICAL EXAMINERS TO DEAL WITH INCOMPETENT PHYSICIANS
 C. CONSIDER THE FEASIBILITY OF MANDATORY INSURANCE FOR PHYSICIANS (THIS CONCEPT IS LINKED SPECIFICALLY TO ITEM 1(C) JOINT AND SEVERAL LIABILITY.)

Physician Discipline: The Board recognized the need for development of legislation to provide additional information that may be necessary for the State Board of Medical Examiners to carry out disciplinary provisions of the Medical Practice Act in the most efficient manner possible. The Board endorsed the concept requiring information on paid claims to be sent from the Department of Insurance to the Department of Professional Regulation:

> "The department shall screen the reports annually and send to the Department of Professional Regulation and the appropriate regulatory board, copies of the reports for all health care providers having paid claims."

And, endorsement of the Department of Professional Regulation recommendations as follows:

1. The penalty for knowingly giving false information when obtaining a license as a health care practitioner (licensed under Chapters 458, 459, 460, 462, 463, 464, 465, 474 and 490, Florida Statutes) will be a third degree felony. This proposal will amend Chapter 455, Florida Statutes.
2. Obtaining a license to practice medicine by fraudulent misrepresentation or fraudulently misrepresenting education, training or experience in obtaining a position as a medical practitioner or medical resident, will result in a third degree felony penalty. This change is proposed for both Chapters 458 and 459, Florida Statutes.
3. The number of times an individual may take the FLEX for state licensure will be limited to three. After failing three times, the applicant will be required to take one year of post graduate training in a program approved by the AMA prior to attempting the examination for a fourth, and final, time. The post graduate training is the responsibility of the individual.

Workers' Compensation Fee Schedule: The Board directed that FMA continue to aggressively pursue via the administrative process, the resolution of inequities in the Workers' Compensation fee schedule, and that the adoption of any specific legislative objectives of the FMA be deferred for the time being.

Indigent Care: The Board approved the development of recommendations to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and further, that the Council be requested to proceed with the recommendation in concert with the Council on Legislation.

Health Care Cost Containment: The Board determined that the FMA place maximum emphasis on developing a plan of action, both legislative and executive, to be considered in addressing the health care cost issue in 1985.

Other Legislative Issues: The Board adopted general positions on other legislative issues as follows:

Support For:

Foreign Medical Graduates: The Board recommended changes that are to be developed by the appropriate representative of the medical schools in Florida and the FMA Council on Scientific Activities in concert with existing state boards and agencies, to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida.

The Board expressed support for legislation by the Department of Professional Regulation that would prohibit licensure of physicians who are graduates from foreign medical schools except by the following criteria:

1. Only those physicians who are graduates from foreign medical schools which are certified or accredited by a nationally recognized certifying or accrediting agency as a result of an on-site visit to the foreign medical school.
2. Only those physicians who have completed minimum requirements for training and licensure in an AMA approved and accredited residency training program.

Alzheimer's Disease: Creation of an advisory committee on Alzheimer's Disease, the Alzheimer's Disease Research Trust Fund and specialized model day care programs (HB77 & SB121).

Indigent Health Care: Support indigent health care funding by additional taxes on such revenue sources as alcohol and tobacco.

Clean Indoor Air Act: Establishment of the Clean Indoor Air Act that prohibits smoking in public places except in designated smoking areas.

Community Hospital Education Council: Increased funding for the Community Hospital Education Council.

Mandatory Car Seat Belts: Requirement for an operator and passengers of a private motor vehicle to wear safety seat belts (HB37, HB47, HB70, SB141).

Trauma Centers: Concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient.

Imminent Scholars Program: Support increased funding for imminent scholars fund.

Drinking Age: Raising the legal age for the consumption or possession of alcoholic beverages from 19 to 21 (HB42, HB54, SB1).

Child Safety Seats: Closes a loophole in the child restraint law that requires all persons transporting a child who is five years or younger in a motor vehicle to use a child restraining device (HB6).

Campaign Financing: Prohibits contributions to candidates who are unopposed to be made after the qualifying date.

Opposition To:

Pharmacy Prescribing: Authorization for certain "Self-care Consultants" to prescribe drugs contained in a formulary without examination and diagnosis by a physician.

Mandated Insurance for Chiropractic Services: Mandates for all insurance policies to include payment for chiropractic services.

Chiropractic School: Any appropriation from general revenue to establish a school of chiropractic in Florida.

Mandatory PLI: Mandates professional liability insurance in the amount of $250,000 for all physicians on a condition for license (HB 23).

Limitation of Expenditures by PACS: Sets up certain limitations on the amount of PAC contributions to candidates.

Use of Drugs by Optometrists: Authorization for optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye.

Hospital Staff Privileges for Non-Physicians: Mandated hospital staff privileges for non-physicians.

Amendments to Medical Practice Act: Any further exemptions being created in the Medical Practice Act would bypass present licensure requirements.

Increased Fees for Physician Licenses: Requires an increase in physicians licensure fees to fund Medicaid.

Review of FMA Legislative Activities

The Florida Medical Association has had a legislative program for many years. In 1969, the FMA established a Capital Office in Tallahassee with a full-time legislative director and supporting staff. Because of the early realization of the relationship between effective political action and successful legislative efforts, the FMA was one of the first state medical associations to establish a political action committee (FLAMPAC). Field offices of the FMA with field directors are now located in Tallahassee, Tampa, Orlando, and Miami.

A key man system (key contact program) was developed many years ago with a physician designated as the key man for each member of the Legislature and Congress. Over the last decade, the FMA has also developed a strong working relationship with the FMA Auxiliary in both political and legislative activities. The Auxiliary has become a very strong force in community action and has established a comparable key contact system which works in close cooperation with that of the FMA. The Auxiliary also established a LegsAlert system that has proven to be very effective on behalf of the FMA in dealing with legislative issues which require immediate action.

Our experiences in the legislative sessions in 1983 and 1984 relative to the professional liability issue and our recent experience with Amendment 9, indicated clearly that we needed to carefully examine the legislative arm of the FMA to see whether it is meeting the demands of a rapidly changing environment.

The Board of Governors, therefore, authorized a review of the legislative program. A team of consultants consisting of Mr. Bill Roberts, AMA Division of Medical Society Relations; Mr. Bob Klinglesmith, Associate Executive Director of the Kentucky Medical Association; and Mr. Greg Hooser, Legislative Counsel of the Texas Medical Association were asked to come to Florida and make a detailed on-site review of the Association legislative and political education activities. This review was to include the FMA's legislative, PAC, field services activities, its relationships with the Auxiliary, county and specialty medical societies, and other groups in the health field that have legislative interests and concerns.

The review has now been completed and a detailed report has been received which indicates that generally the FMA's legislative efforts have been historically very effective, and with the exception of its tort reform effort, compares very favorably with that of most other state medical societies. We must recognize, however, in light of Dr. Sammons' remarks, that Florida is now a bell weather state for change. Therefore, we must continue to respond to the rapid, revolutionary changes that are occurring, and our legislative program should be strengthened in every way possible.

This report and the recommendations of the consultants have received very careful review, and steps are already underway to implement the recommendations which include:

1. Careful evaluation of all staff responsibilities for the FMA legislative and political education activities with appropriate action as necessary to clarify and delineate the role, lines of authority and responsibilities and functions of the FMA headquarters, capital and field offices to ensure the best possible coordination and operational efficiency in carrying out these activities.
2. Expand the responsibilities of the Council on Legislation in carrying out the policies of the House of Delegates using general guidelines established by the Board of Governors.
3. Strengthen working relationships with county medical societies with these efforts directed both at the executives of the county medical societies and the physician members.
4. Strengthen and expand the cooperative efforts with the Auxiliary in our legislative and political education activities.
5. Develop a better working relationship with specialty societies and their lobbyists, if these societies have such lobbyists.
6. Develop a better working relationship with other groups such as business organizations, labor unions, civic and senior citizen organizations.
7. Improve liaison with the executive and regulatory branches of the Florida Government.
8. Incorporate in the FMA legislative program issues other than those that are perceived by the public and the legislature to be solely for the benefit of physicians.
9. Expand FLAMPAC activities to include more assistance to candidates such as benchmark surveys, demographic studies, independent expenditures and more physician and spouse participation in the candidates' campaigns.
10. Maximize efforts to keep physicians informed of the Association's legislative programs and activities.



Kenneth C. Kiehl, M.D., Sarasota, Chairman, Reference Committee No. IV, presents his Reference Committee report.

This analysis and refinement of the FMA's legislative arm of the FMA will greatly enhance the legislative capability in 1985 and in the future, to cope with the numerous, complex, and at times the seemingly overwhelming legislative problems that face medicine.

The motion of the Reference Committee that the portions of the Council on Specialty Medicine Report referred to this committee be filed carried.

The motion of the Reference Committee that the portions of the Board of Governors Report A referred to this Committee be filed carried.

The motion of the Reference Committee that the portions of the Board of Governors Report B referred to this Committee be filed carried.

RESOLUTION 85-5
Assignment of Insurance Benefits
Dade County Medical Association

A Substitute Resolution 85-5 was offered by the Reference Committee and its adoption moved. The motion carried and Substitute Resolution 85-5 was adopted.

Substitute Resolution 85-5
Assignment of Insurance Benefits

RESOLVED, That the FMA Board of Governors be asked to consider undertaking legislative efforts immediately to change Florida Statute 627.736 (which currently allows insurers to honor signed assignments) to provide that insurers shall honor signed assignments, and to provide further that whenever previously signed assignments are changed, all affected parties be notified by the insurer.

RESOLUTION 85-8
Expert Testimony Requirements
Dade County Medical Association

The motion of the Reference Committee that Resolution 85-8 be referred to the Board of Governors carried.

Resolution 85-8

Expert Testimony Requirements

(Referred to Board of Governors)

Whereas, Malpractice premiums are exorbitant in certain areas of the state; and

Whereas, An expert witness is, by definition, practicing medicine in the state of Florida; and

Whereas, We are plagued by physicians from outside the state and without licenses to practice medicine in the state of Florida testifying in malpractice cases; therefore be it

RESOLVED, That the FMA take immediate action to promote the passage of state legislation requiring that any physician offering expert testimony in any malpractice case in Florida be licensed to practice in the state and be familiar with the medical practices in the community where the alleged malpractice occurred.

RESOLUTION 85-9
Mandatory FMA Membership
Dade County Medical Association

The motion of the Reference Committee that Resolution 85-9 be referred to the Board of Governors carried.

RESOLUTION 85-9

Mandatory FMA Membership

(Referred to Board of Governors)

Whereas, Physicians are constantly being harangued to "clean our own houses;" and

Whereas, There is presently no state legislation allowing for such actions; and

Whereas, A physician need not be a member of organized medicine to practice medicine in this state; and

Whereas, The county and state medical associations are best suited to monitor errant physicians; therefore be it

RESOLVED, That the FMA seek the passage of legislation mandating membership in the Florida Medical Association as a prerequisite for maintaining a Florida medical license and for hospital staff privileges with reference to Doctors of Medicine and osteopathy; and be it further

RESOLVED, That the FMA seek the passage of legislation allowing for some autonomy of the state and local medical societies for disciplining their members.

RESOLUTION 85-12
Limitations to Medical Malpractice Liability
Dade County Medical Association

RESOLUTION 85-16
Workmen's Compensation Approach to Medical Liability Insurance
Lee County Medical Society

Substitute Resolution 85-12, combining Resolutions 85-12 and 85-16, offered by the Reference Committee was referred to the Board of Governors as amended.

Substitute Resolution 85-12
Limitations to Medical Malpractice Liability
(Referred to Board of Governors)

RESOLVED, That medical liability on a no-fault and "workers' compensation" basis, with pre-determined limits of liability, be endorsed as a viable alternative to the present tort system.

RESOLUTION 85-18
Motorcycle Insurance Requirements
Lee County Medical Society

The motion by the Reference Committee that Resolution 85-18 not be adopted carried.

RESOLUTION 85-19
SBME Licensure Renewal Procedures
Polk County Medical Association

A Substitute Resolution 85-19 was offered by the Reference Committee and its adoption as amended moved. The motion carried and Substitute Resolution 85-19 was adopted as amended.

SUBSTITUTE RESOLULTION 85-19
SBME Licensure Renewal Procedures

RESOLVED, That the FMA seek establishment of appropriate mechanisms that would enable the FMA to contact physicians and their county medical societies when a medical license has not been renewed.

RESOLUTION 85-24
Medical Licensure
Duval Medical County Society

The motion by the Reference Committee that Resolution 85-24 be adopted carried.

RESOLUTION 85-24
Medical Licensure

RESOLVED, That the Florida Medical Association reaffirm its position to actively oppose any proposed legislation providing exception under the Medical Practice Act; and be it further

RESOLVED, That the Florida Medical Association inform all parties seeking exception to the Medical Practice Act of its position on this issue, and request those parties to cease their attempts to seek these exceptions.

RESOLUTION 85-25
HMO Financial Responsibility
FMA Council on Hospital Medical Staffs

A Substitute Resolution 85-25 was offered by the Reference Committee and its adoption as amended moved. The motion carried and Substitute Resolution 85-25 was adopted as amended.

SUBSTITUTE RESOLUTION 85-25
HMO Financial Responsibility

RESOLVED, That the Florida Medical Association seek passage of legislation (and/or modification of legislation currently being considered) to require HMO's to meet their financial responsibility to patients, physicians, and hospitals in the circumstance when a patient is given emergency care in a hospital for that which is considered by the physician or physicians delivering such care to be a bona fide emergency, and the HMO does not arrange timely provisions of services, and the physician or hospital are unable to obtain timely authorization for such care; and be it further

RESOLVED, That legislation be immediately sought to require HMO reimbursement of non-participating physicians within a reasonable time period (i.e., within thirty (30) days after delivery of care).

The Chairman expressed, on behalf of the Committee, his deep appreciation to FMA Staff, Mr. Donald Weidner, Mrs. Lucy Mohs, and Mrs. Diane Bowker for their assistance in the preparation of this report. The Committee also thanked all members of the Florida Medical Association who appeared before this Committee. The Chairman also thanked the members of this Committee, Dr. David R. Arrowsmith, Dr. Thomas R. Busard, Dr. E. Joan Barice, Dr. Charles A. Dunn, Dr. Arnold L. Tanis, Dr. Samuel L. Renfore, Dr. Louis C. Murray, AMA Delegate Advisor, and Dr. Sanford Mullen, AMA Alternate Delegate Advisor.

The motion that the report of Reference Committee IV be adopted as amended carried.

Report of Reference Committee No. V Medical Economics

Dr. Perry called the Chairman and members of the Reference Committee No. V, Medical Economics, to present their report.

Dr. Charles P. Hayes Jr., Chairman, and his Committee came forward to present the report of Reference Committee No. V, Medical Economics.

Report of the Council on Medical Economics

The motion of the Reference Committee that the Report of the Council on Medical Economics and the Supplemental Report of the Council on Medical Economics be filed carried.

Council on Medical Economics

Charles P. Hayes Jr., M.D., Chairman

The Council on Medical Economics held four meetings during the 1984-85 Association year: July 13, 1984, September 13, 1984, December 21, 1984, and February 18, 1985. The Council reviewed many medical economics issues during the Association year. The establishment of several subcommittees under the purview of the Committee on Health Care Delivery allowed many specific issues relating to medical economics to be addressed. Under the Committee on Health Care Delivery, four subcommittees were established including the Subcommittee on Business Coalition, Subcommittee on Government Programs, Subcommittee on Health Care Financing, and the Subcommittee on Health Care Delivery Mechanisms. These Subcommittees reviewed a tremendous amount of material and presented several recommendations to the Board of Governors. Major effort was devoted to the development of the Florida Medical Foundation Peer Review Organization proposal (FMF-PRO) that was submitted to the Health Care Financing Administration, the development of testimony was presented to the Three-Member Panel to request that an increase be granted to the Workers' Compensation Femur data base, and initiation of the development of the revised 1986 Florida Relative Value Studies. All the Committees under the Council on Medical Economics were very active. A summary of these activities is reported below.

Committee on Workers' Compensation

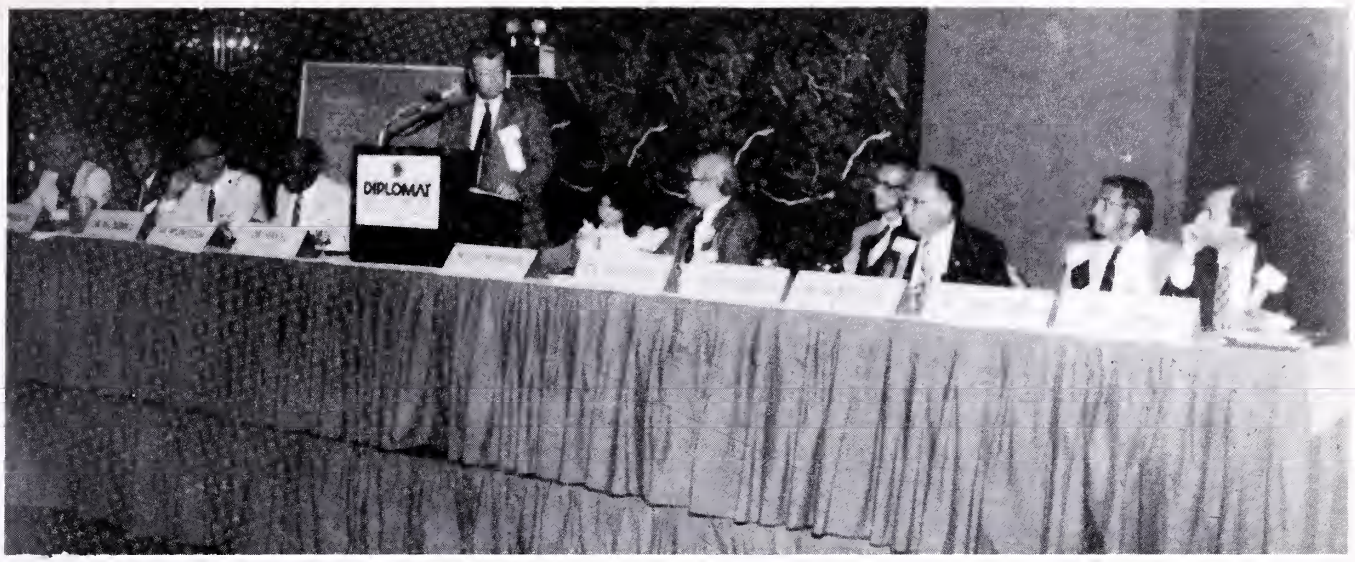
The Committee on Workers' Compensation, chaired by Howard A. Kurzner, M.D., presented testimony to the Three Member Panel on two separate occasions during the 1984-85 Association year supporting the establishment of an increase in Workers' Compensation fee schedule. Information presented to the panel included a statistical analysis comparing the Workers' Compensation Femur data base reimbursement rates and private health insurance program reimbursement rates for similar procedures. In addition, presentations were given on the effect of increasing price levels on the economic status of doctors, the effect of changing maximum allowances on the cost of medical care in Florida, and an analysis of the appropriate increases needed for Workers' Compensation maximum reimbursement allowances for Medical Services. Additionally, a survey was conducted by Florida State University that illustrated the percentage of doctors satisfied with the Workers' Compensation fee schedule, the number of doctors currently treating Workers' Compensation patients, and the increase or decrease in the percentage of Workers' Compensation patients treated by physicians. In addition, the survey also illustrated responses to questions pertaining to satisfaction with the fee schedule broken down by the various practice specialties and the Medicare charge areas. Additional testimony presented included comparing changes in the consumer price index, inflation rates, and cost of living increases as compared with physicians office practices expenses. As a result of the testimony that was presented to the Three-Member Panel, a 4.2% increase in the reimbursement schedule was granted in January, 1985, which will go into effect July 1, 1985.

Committee on Peer Review Organizations

The Committee on Peer Review Organizations, chaired by Charles P. Hayes Jr., M.D., was responsible for assisting the Professional Review Organization of Florida, Incorporated, in developing a PRO proposal to be submitted to the Health Care Financing Administration. A great deal of time and staff effort was devoted to the development of the PRO proposal. Unfortunately, the Foundation was unsuccessful in its bid for the PRO contract for the State of Florida. The FMA has filed protest with the General Accounting Office as a result of what appears to have been major flaws in the awarding of the contract and is awaiting a final decision of the protest. Also, a suit has been filed with the Federal District Court in Washington, D.C., under the Freedom of Information Act as a result of the Health Care Financing Administration's failure to supply pertinent information pertaining to the negotiation and contract procedures. The final proposal submitted by the Florida Medical Association was a detailed, four volume report totaling over 700 pages of material. The PRO Committee has been actively monitoring the activities of the Professional Foundation for Health Care and has requested county medical societies to submit any problems they have encountered with the implementation of PRO. The Committee has studied these problems and has met with Professional Foundation for Health Care representatives to try to eliminate some of the problems that the membership has identified.

Committee on Relative Value Studies

The Committee on Relative Value Studies, chaired by Joel W. Mattison, M.D., is currently in the process of developing a revised



Reference Committee V (Medical Economics) was chaired by Charles P. Hayes Jr., M.D., Jacksonville. Left to right: John M. Canakaris, M.D., Bunnell; Robert L. Dawson, M.D., St. Petersburg; Jack W. MacDonald, M.D., Tallahassee; Charles B. McIntosh, M.D., Jacksonville; Dr. Hayes; Ms. Lynn Mobarak, Recorder; Miguel Figueroa, M.D., North Miami Beach; Ralph E. Rydell, M.D., Tampa; Dick L. Van Eldik, M.D.; Lake Worth; Joseph C. Von Thron, M.D., Cocoa Beach; Alan J. Yesner, M.D., Fort Lauderdale.

edition to the *1982 Florida Relative Value Studies* to be entitled *1986 Florida Relative Value Studies Book*. The revised Relative Value Studies will be based on the AMA CPT-4 1985 edition in its entirety. It will also be based on the 1983-84 Charge Data. Throughout the Association year, the Committee has maintained regular correspondence with physicians who had questions pertaining to the Relative Value Studies and have worked with the various specialty societies in addressing specific problems relating to the RVS. It is anticipated that the publishing of the 1986 Florida RVS will be completed sometime in late 1985.

Committee on Health Care Delivery

The Committee on Health Care Delivery, chaired by William J. Garoni, Jr., M.D., was quite active with 26 major recommendations to the Council on Medical Economics emanating from its four subcommittees, which proved to be an effective method in which to deal with the responsibilities assigned to the Committee. In general, the Committee and its subcommittees placed major emphasis on making proactive recommendations on many issues including the legislature's newest cost containment bill, the landmark Health Care Consumer Protection and Awareness Act of 1984, Chapter 84-35 Laws of Florida.

Subcommittee on Business Coalition

The Subcommittee on Business Coalition, chaired by Thomas E. McKell, M.D., reviewed a survey on business coalitions sent to all county medical societies, which disclosed that there are seven business coalitions in Florida. They are:

(1) South Florida Health Action Coalition
(2) Palm Beach Area Health Coalition
(3) Employer Health Care Group of Polk County
(4) Hillsborough Coalition for Health
(5) Central Florida Health Coalition
(6) Pasco County Health Care Coalition
(7) Health Care Cost Containment Coalition of the Greater Jacksonville Chamber of Commerce

It was noted that involvement with business by the county medical society in conjunction with the chamber of commerce provides a potentially good mechanism for county coalitions to develop cost containment health plans. The Subcommittee on Business Coalition recommended that the Technical Assistance Panel be established within the Florida Medical Association to identify cost-effective medical practice procedures to assist county medical societies in their involvement with business coalitions. The panel would also enable the Florida Medical Association to have a formal mechanism to provide technical information on the practice of medicine to the Office of Technical Assistance created by the Health Care Consumer Protection and Awareness Act.

Subcommittee on Health Care Delivery Mechanisms

The Subcommittee on Health Care Delivery Mechanisms, chaired by Robert G. Isbell, M.D., stressed the importance of medical economics and the need for the Florida Medical Association to monitor and report on the development of PPOs, HMOs, IPAs, and various hospital programs that affect the practice of medicine in this state. It further recommended that the Florida Medical Association develop a physicians guide on contracting and negotiating with alternative health delivery systems and hospital programs. In emphasizing long-range planning, the Subcommittee articulated the need to review the primary care and prepaid Medicaid program of the Department of Health and Rehabilitative Services and the financing on contract with private practice physicians.

Subcommittee on Health Care Financing

The Subcommittee on Health Care Financing, chaired by Jack W. MacDonald, M.D., identified as a critical concern the Florida Medical Association's need to interface with health insurance companies. The Subcommittee recommended that the new Health Care and Insurance Committee of the House of Representatives might serve as the forum for organized medicine and insurance companies to jointly develop health insurance plans involving the practice of medicine. It further felt that the programmatic staff of the Florida Medical Association needs to be involved with

the Legislature in terms of providing direct expertise on a routine basis in the development of health legislation. Other recommendations involved working with the Health Care Financing Administration (HCFA), reporting on the impact of Diagnostic Related Groups (DRGs) on medical practice, and developing an effective mechanism to assess the quality of care in Health Maintenance Organizations.

Subcommittee on Government Programs

The Subcommittee on Government Programs, chaired by James K. Conn, M.D., expressed support for the Governor's State Plan, which includes the concepts of growth management and strategic planning. A major recommendation was the establishment of a Medical Assistance Panel to advise the Department of Health and Rehabilitative Services on the development of policy and programs. It further acknowledged the need for an informed membership by recommending that the 1986 Leadership Conference include a State Government Workshop. The Subcommittee on Government Programs throughout 1985-86 will continue to associate with government entities and programs to establish access for medical input in the development of state health policy.

Supplemental Report Council on Medical Economics

This Supplemental Report updates the report of the Council on Medical Economics in order to include the Council's meeting of March 29, 1985, held in Tampa, at which David H. Pingree, Secretary of the Department of Health and Rehabilitative Services (HRS) was the featured guest, along with James T. Howell, M.D., Deputy Secretary. The purpose of the meeting was to describe the structure, functions, objectives, and recent recommendations of the Council on Medical Economics, in order to determine methods by which HRS and the Florida Medical Association (FMA) can work more closely to meet the health needs of Florida's citizenry.

The Chairman of the Council on Medical Economics and the Chairmen of the Council's committees and subcommittees each described the recommendations of the Council, as approved by the Board of Governors, which specifically relate to government. These recommendations are:

- Priority of Medical Planning
- Technical Assistance Panel and Exchange of Information
- Long Range Planning
- Indigent Care
- Primary Care
- Medicaid Alternatives
- House of Representatives Committee on Health Care and Insurance
- HMO Accreditation and Quality of Health Care
- Medical Assistance Panel
- State Government Workshop
- The Governor's State Plan and Cost Containment

Both Secretary Pingree and Dr. Howell complimented Dr. Hodes and the entire Council on Medical Economics on the positive interrelationship with governmental programs that their recommendations entail. At which point the Council on Medical Economics urged that the House of Delegates strongly endorse these recommendations as approved by the Board of Governors.



The annual Past Presidents' Breakfast is always a highlight. Seated (left to right): Robert E. Windom, M.D., Sarasota (1982); Joseph C. Von Thron, M.D., Cocoa Beach (1973); J. Lee Dockery, M.D., Gainesville (1983); former FMA Executive Vice President W. Harold Parham, D.H.A., Jacksonville; Jere W. Annis, M.D., Lakeland (1958); H. Philip Hampton, M.D., Tampa (1965); and Samuel M. Day, M.D, Jacksonville (1964). Standing (left to right): Louis C. Murray, M.D., Orlando (1977); T. Byron Thames, M.D., Orlando (1980); Jack A. MaCris, M.D., St. Petersburg, (1976); Sanford A. Mullen, M.D., Jacksonville (1981); Richard S. Hodes, M.D., Tampa (1979); Vernon B. Astler, M.D., Orlando (1980); O. William Davenport, M.D., Miami (1978); and George S. Palmer, M.D., Tallahassee (1966).

Secretary Pingree and Dr. Howell each discussed the operation of the Executive and Legislative Branches of Government, including a description of the budgetary process which for all executive agencies begins a year in advance of its consideration by the Legislature. For example, the current budget now before the Legislature for fiscal year 1985-86 began April 1, 1984. Similiarly, April 1, 1985, is the date on which all executive agencies begin preparation of their budget requests for fiscal year 1986-87, which will be submitted to the Legislature in 1986. Dr. Hodes stressed the need for FMA to develop a clear relationship to the budgetary process of state government; for it is the budget and subsequent appropriations act that generate programs affecting the delivery of health care services.

Secretary Pingree and Dr. Howell welcomed the opportunity of input from the new Medical Assistance Panel, which is to consist of the Chairmen of FMA's councils, and which is to be involved at the policy-making level of HRS.

The Council on Medical Economics stated that a definitive action plan needs to be drawn for each of the recommendations passed and approved by the Council. Further, the Council made a specific recommendation that a State Government Calendar, be prepared with key dates identified, such as the April and November budget dates, as well as other governmental key dates identifying activities of interest to FMA. The Council also recommended that the work plans for each approved recommendation also contain trigger dates to initiate action toward implementing those recommendations.

Secretary Pingree stated that the Department of Health and Rehabilitative Services looks forward to increased FMA involvement with HRS, and that periodic dates throughout each year should be set aside for meetings between the Department and FMA. In conclusion, Secretary Pingree and Dr. Howell commended the Council on Medical Economics for the positive steps it has taken, and conveyed to the Council that the door to the Office of the Secretary of HRS is always open to FMA.

Report of the Council on Hospital Medical Staffs

The motion that the report of the Council on Hospital Medical Staffs be filed carried.

Council on Hospital Medical Staffs
Thomas M. Daniel, M.D., Chairman

Pursuant to the direction of the 1984 House of Delegates, the FMA Bylaws were amended to provide for the implementation of the Council on Hospital Medical Staffs. Membership of the Council shall consist of two representatives from each medical district nominated by county medical societies and approved by the FMA Board of Governors. Nominations have been received from the county medical societies, and Council members have been approved by the Board.

Communications have been established with the hospital medical staffs of each hospital in the state regarding the development of the Council and the functions of the AMA/HMSS. In an effort to develop liaison and to address the concerns and issues of mutual benefit, the Chairman of the Council has met with the Florida Hospital Association.

The Council held its first meeting on January 19, 1985. It also sponsored a workshop on Hospital Medical Staffs at the 1985 FMA Leadership Conference. Thomas R. Reardon, M.D., Governing Council of the AMA Hospital Medical Staff, gave an overview of the AMA activities pertaining to hospital medical staffs and an update of current problems hospital medical staffs are facing on a national level.

Two handbooks have been developed, one details the responsibilities of Council members, and the other assists county medical societies in the implementation of local hospital medical staff committees. A quarterly newsletter is also being developed reporting the activities of hospital medical staffs for distribution to hospital medical staffs and county medical societies. Council members strongly recognize the importance of developing a mechanism in which local hospital medical staffs may have effective input. As a result, county medical societies have been encouraged to develop local hospital medical staff committees. The local hospital medical staff committees will help form the communications network necessary to provide input from all hospital medical staffs and will function by communicating bi-directionally with the Council on Hospital Medical Staffs.

The Council recommended the development of a Committee on Risk Management to study the malpractice crisis and to develop an educational program assisting physicians practicing in private or hospital settings with the prevention of malpractice suits.

Recognizing that the membership is currently not totally united, the Council has established addressing these concerns as one of its immediate goals. Several of the long term ongoing goals of the Council include: studying the changing medical care environment and its potential effect on hospital medical staffs and organized medicine; developing services necessary to strengthen hospitals/health facility medical staffs; increasing awareness of issues that are affecting physicians as members of medical staffs; and providing an avenue for hospital medical staffs to have access to the policymaking body of the FMA.

The Council has been very active in its first year of existence and, as a result, has initiated a study on health professionals seeking hospital medical privileges. The Council has assisted the Council on Legislation in studying several major issues and offered assistance to the Committee on PRO in its efforts to monitor PRO activities. These subjects will be carefully studied and the Council's findings will be reported back to the Board of Governors.

The motion of the Reference Committee that the portions of the Report of Florida Medical Foundation — PMUR be filed carried.

The motion of the Reference Committee that the portions of the Report of Florida Medical Foundation — Professional Review Organization of Florida be filed carried.



Mrs. Estelle Dobbins was presented a plaque in memory of her husband, Dr. Burns A. Dobbins by Dr. Frank C. Coleman, FMA President and Dr. Kenneth C. Kiehl, PMUR Chairman.

Report E of the Board of Governors

The motion of the Reference Committee to adopt Report E of the Board of Governors carried.

Recommendation No. E-1 was adopted as presented.

FMA Councils and Committees

COUNCIL ON MEDICAL ECONOMICS

The annual report on the major activities of the Council on Medical Economics is included in this section of the Delegates' Handbook. The Board of Governors has carefully reviewed the activities of the Council during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Freestanding Emergency Centers: The Board approved in principle the FMA working in concert with the University of Florida Center for Health Policy Research in conducting a survey of Freestanding Emergency Centers in Florida.

Standardized Health Claim Form: The Board determined that information regarding the Standardized Health Claim Form be provided to county medical societies for dissemination to their members as they deem appropriate; and further, that the FMA advise the membership regarding changes in the form and revised portion of the narrative through appropriate FMA newsletters and publications; and further, to authorize the distribution of the form and narrative to the membership if Blue Cross and Blue Shield of Florida, Inc. wishes to underwrite the cost thereof.

Workers' Compensation: The Board referred to the Council on Legislation for review the recommendation that the FMA seek repeal of the section of the Workers' Compensation Law that establishes a three-member panel.

Approved and referred to the Council on Legislation for appropriate action the recommendation that FMA seek repeal of that section of the law which mandates that Workers' Compensation reimbursement shall have statewide applicability.

The Board approved the recommendation that the FMA continue to work with the office of Medical Services and the three-member panel in developing testimony to illustrate the need to increase the reimbursement level to an equitable level of the Femur Data Base for 1986.

The Board directed that FMA submit a letter of protest to the three-member panel detailing the dissatisfaction with the small increase in the fee schedule and to reiterate some of the testimony that was presented that clearly indicated the need for a more equitable increase. (Appendix E-1).

Exchange of information: The Board approved the recommendation that the FMA interact with the Office of Technical Assistance, now in the Department of Insurance, to be transferred to the Governor's office by December 1985 for the purpose of exchanging information regarding alternative health delivery systems.

Indigent Care: The Board approved the development of recommendations to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and further, that the Council be requested to proceed with the recommendation in concert with the Council on Legislation.

Primary Care: The Board urged the Department of Health and Rehabilitative Services that an on-going status report of the DHRS Primary Care Program be provided to the FMA and the following four specialty societies regarding the appropriate designation to areas with significant needs for primary care:

Florida Academy of Family Physicians
The Florida Pediatric Society
The Florida Obstetric and Gynecologic Society
The Florida Society of Internal Medicine

Medicaid Funding: The Board directed that the FMA examine all alternative prepaid Medicaid plans and determine the extent of funding needed to establish such programs for implementation through county medical societies.

Medical Economics Priority: The Board of Governors directed that priority be given to the establishment of a section within the Medical Economics Department to monitor the rapid escalation of alternative health care delivery systems and the impact on the traditional fee for service system of health care delivery; and that this be carried out in the most expedient manner possible within the current staff structure of the FMA.

Physician Contracting Guide: The Board authorized the development of a physician's guide on contracting and negotiating with alternative health care delivery systems in hospital programs, and that this be implemented as part of the activities of the health care delivery system section to be established in the FMA Department of Medical Economics.

Medico Legal Hotline: The Board approved the establishment of a medico legal hotline to assist physicians confronted with potential difficulties and that this program be evaluated in six months to determine the extent of activity and cost benefit rates of the program.

House Committee On Health Care And Insurance: The Board directed that FMA maximize interaction with the Florida House Committee on Health and Insurance, and encourage the Committee to establish dialogue between the major insurance companies and the FMA regarding the financing of health care services and that FMA offer to assist the House Committee in its deliberations on cost containment, cost effectiveness, and quality of care.

Health Care Financing Administration: The Board approved the recommendation that the FMA, as much as possible, interrelate with the Federal Health Care Financing Administration, in addition to the State Office of Technical Assistance and other related State and Federal agencies to provide input in the development of health care financing.

DRGs: The Board approved the recommendation that the Council on Specialty Medicine in concert with FMA's recognized specialty groups document the impact of DRGs on specialty and general practices, and in conjunction with the Subcommittee on Health Care Financing, report to the Board of Governors on a timely basis the impact of DRGs on the practice of medicine.

HMOs: The Board requested county medical societies to provide the FMA with documented instances of quality of care concerns in respect to HMO health care delivery systems. The Board will also study the development of a form to be used to request from county medical societies instances of concern of poor quality of care rendered by health care delivery systems in Florida.

Medical Assistance Panel: The Board approved the establishment of a medical assistance panel to advise HRS through input at the policy-making level; and further, for this panel to enhance the capabilities of FMA staff to serve as a resource in working with HRS staff in providing medical input and assistance in the planning, development, and implementation of health programming.

Peer Review For Fee Disputes: The Board approved the recommendation that the FMA encourage the AMA to seek legislation to modify the current anti-trust laws to permit resumption of peer review for fee disputes.

Relative Value Studies: The Board approved the recommendation that FMA base the 1986 edition of the *Florida Relative Value Studies* on the AMA CPT4 1985 edition.

HMO Accreditation: The Board referred to the Council on Legislation the recommendation that FMA encourage the Department of Insurance to create an HMO accreditation Commission and that if the Department does not accept this recommendation,



FMA's delegation to the American Medical Association prepared itself to attend the upcoming June AMA Annual Meeting in Chicago. Seated (left to right), Luis M. Perez, M.D., Sanford; Charles J. Kahn, M.D., Pensacola; Richard G. Connar, M.D., Tampa; Joseph C. Von Thron, M.D., Cocoa Beach; Charles K. Donegan, M.D., St. Petersburg; Frank C. Coleman, M.D., Tampa; Rufus K. Broadaway, M.D., Miami, AMA Board of Trustees; Sanford A. Mullen, M.D., Jacksonville; Joseph T. Ostroski, M.D., Miami. Standing (left to right): Louis C. Murray, M.D., Orlando; J. Lee Dockery, M.D., Gainesville; T. Byron Thames, M.D., Orlando; Dick L. Van Eldik, M.D., Lake Worth; O. William Davenport, M.D., Miami; Vincent P. Corso, M.D., Miami; Eugene G. Peek Jr., M.D., Ocala; James B. Perry, M.D., Ft. Lauderdale; James W. Walker, M.D., Jacksonville.

then the FMA seek passage in legislation to accomplish the goal. The Board also directed that FMA seek appropriate avenues to assure that quality medical care is provided by all HMOs, including those provided by the HRS prepaid Medicaid plan.

PRO: The FMA House of Delegates at its 1983 meeting adopted Resolution 83-15 and Recommendation No. E-1 of the Council on Medical Economics, which authorized the FMA through the Florida Medical Foundation or other appropriate entity, to apply for designation as a statewide PRO for the state of Florida. Pursuant to the House Action, the Board approved the establishment of the Professional Review Organization of Florida, Inc. (PROF), which was charged with the responsibility of developing the PRO proposal. The PROF Board was comprised of the following physicians:

Charles P. Hayes Jr., M.D., Jacksonville
Daniel L. Seckinger, M.D., Miami
James D. Morgan, M.D., Winter Haven
Charles E. Cernuda, M.D., Tampa
James M. Potter, M.D., Pensacola
John Hackenberg, D.O., Jacksonville
Perry M. Dworkin, D.O., Miami

The FMA owes a tremendous debt of gratitude to these dedicated physicians, along with the FMA staff and a number of highly qualified consultants who spent many weeks developing a lengthy and detailed Request for Proposal (RFP), consisting of two full volumes, which was submitted by the Professional Review Organization of Florida, Inc. (PROF, Inc.) to the Health Care Financing Administration (HCFA) on April 27, 1984. The Technical Proposal consists of 300 pages of narrative in addition to 37 exhibits and 12 appendices. The Business Proposal consists of 10 pages of narrative, five appendices and six exhibits. More than 4364 physicians submitted cards in support of the PROF.

The Statewide Peer Review Organization contract was awarded by the Health Care Financing Administration (HCFA) to the Professional Foundation for Health Care (PFHC), of Tampa, on July 13.. At its meeting on July 18, the FMA Board of Governors directed that FMA submit an immediate letter of protest to the U.S. General Accounting Office regarding HCFA's awarding of the contract to the PFHC and that FMA pursue all administrative and legal remedies available in determining why the proposal of the Professional Review Organization of Florida (PROF), which is a physician-sponsored organization and was supported by the FMA and its component county medical societies, the Florida Osteopathic Medical Association, Florida Hospital Association, Florida Nursing Association and many other allied organizations, was not accepted. All information regarding each of the proposals submitted and the methods of evaluation regarding the award of the contract by HCFA was requested under the Freedom of Information Act in order for the Board to make a determination as to what appropriate action should be taken regarding the awarding of the contract.

The Board at its meeting in October 1984, received a status report on the protest. The Board instructed FMA Legal Counsel, in coordination with the FMA's Washington attorneys, to continue the protest and make every effort to seek an early decision by the General Accounting Office and a reversal of the decision of the Health Care Financing Administration in awarding the contract to the PFHC. The Board further directed that the FMA continue to pursue the lawsuit filed under the Freedom of Information Act for release of all necessary documentation regarding the PRO contract from the Health Care Financing Administration. The Board further directed that the matter of the award of the Florida PRO contract be referred to the American Medical Association and that the AMA be advised of the FMA's deep concerns about the adverse national implications resulting from the manner in which this law is being promulgated by the Health Care Financing Administration, and further, that this information be conveyed in an appropriate resolution to the AMA House of Delegates at its Interim Meeting in December. (Please refer to Board Report C, [blue], Reference Committee III in the Delegates' Handbook.)

A fair hearing was conducted in November 1984, before a hearing officer in Washington D.C., and final briefs were submitted in Federal Court challenging HCFA's refusal to release needed information under the Freedom of Information Act. As of the date of

this report, a ruling on the FMA's protest had not been rendered. An updated report on the PRO will be included in a Supplemental Report to the House of Delegates.

The Board at its meeting in March 1985, directed that the FMA pursue the protest of the PRO award until the results of the fair hearing have been fully determined.

The Board also directed that FMA will continue to monitor the activities of the Professional Foundation for Health Care, Tampa, and continue to collect and evaluate any of the problems FMA members encounter with the PRO.

The Board encouraged county medical societies and recognized specialty groups to participate in the monitoring process of the Professional Foundation for Health Care and report problems to the FMA PRO Committee, and further, that specialty groups be encouraged to provide technical assistance and advice pertaining to their individual specialties to the Committee on PRO.

The Board also requested the Council on Hospital Medical Staffs to monitor the activities of the PRO and report problems to the FMA Committee on PRO.

COUNCIL ON HOSPITAL MEDICAL STAFFS

The Annual Report on the major activities of the Council on Hospital Medical Staffs is included in this section of the Delegates Handbook. The Board has carefully reviewed the activities of this important Council during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Establishment and Charge of Council: In May 1984 the FMA House of Delegates approved a recommendation of the Board of Governors that a Council on Hospital Medical Staffs be established. The Bylaws were amended to include this Council and to give the Council a vote in the House of Delegates.

The decision to establish this Council was made after a review of the complex problems facing medical staffs in Florida and a detailed study of the AMA Council on Hospital Medical Staffs, which was established in 1982. It will provide a forum for addressing the dramatic changes that are occurring in our health care delivery system. There are 217 acute care hospitals in Florida. Of these, 77 are proprietary, 88 are nonprofit, and 52 are government owned. The rapidity of change in Florida is especially dramatic because of the high percentage of Medicare beneficiaries (over 18%), the cost containment efforts of the federal government in Medicare and Medicaid programs and those of business coalitions in the private sector.

The Council is comprised of nine members, two from each of the four medical districts and a chairman appointed by the President. The district members are appointed by the FMA Board of Governors from nominations received from the component county medical societies. Council members must be Florida Medical Association members in good standing. The Council is currently comprised of the following physicians:

Thomas M. Daniel, M.D. Chairman

District A - North Medical District
Richard W. Cunningham, M.D.
William R. Bell Jr., M.D.
District B - West Medical District
Marc Freedman, M.D.
Ray Barnes, M.D.
District C - East Medical District
Leonard Urdman, M.D.
Richard W. Snodgrass, M.D.
District D - South Medical District
Joseph Harris, M.D.
Eno Kaany, M.D.

This Council, as do all other FMA councils, reports to the Board of Governors.

The Council will provide for representation of hospital medical staffs and serve in an advisory capacity to hospital medical staffs throughout the state. At least twice annually, representatives of hospital medical staffs will have the opportunity to meet with the Council to discuss common issues and concerns. The Council will develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches to problems.

Because of economic pressures brought about by prospective pricing such as DRGs, PROs, HMOs, PPOs and business coalitions for health, hospitals are paying more attention than ever to the make-up of their medical staffs. Many hospitals are keeping a detailed profile of each member of the medical staff. Others are going into joint ventures with members of the medical staff to develop facilities for ambulatory care as a replacement of inpatient care. Other joint ventures may include HMOs, medical office buildings and diagnostic centers.

Some hospitals are looking carefully at the total number of physicians on their medical staff and the specialty mix of these members. Others are developing mechanisms for applying "golden handcuffs" to members of the medical staff, thus binding them tightly to the hospital.

The future economic survival of both the hospitals and the physicians may well depend on a satisfactory working relationship between them. This Council on Hospital Medical Staffs provides a way whereby this relationship can be established.

The major issues to be addressed by this Council include: lack of medical staff voice in hospital planning and in hospital governing board decisions; effect of changes in hospital ownership on medical staffs; competition between hospital ambulatory services and office based practices; hospital diversification into other profit making activities; closed medical staff arrangements and/or exclusive contracts; interpreting and complying with JCAH standards; role of nonphysician health care providers in the hospital; interspecialty jurisdiction in delineation of privileges; and hospital cost containment. The Council has also been charged with the major responsibility of developing a risk management program for physicians serving on the hospital medical staff.

Short and Long-Term Goals

The Board received an update on the formation of the Council on Hospital Medical Staffs and the establishment of short and long-term goals of the Council.

RECOMMENDATION NO. E-1

THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING SHORT-TERM AND LONG-TERM GOALS OF THE COUNCIL ON HOSPITAL MEDICAL STAFFS:

SHORT-TERM GOALS

A. DEVELOP AND STUDY METHODS FOR IMPLEMENTING RISK MANAGEMENT FROM THE POINT OF VIEW OF THE PHYSICIAN AS HE FUNCTIONS AS A MEMBER OF HIS HOSPITAL MEDICAL STAFF.

B. ENCOURAGE THE DEVELOPMENT OF LOCAL COUNTY HOSPITAL MEDICAL STAFF COMMITTEES BY PROVIDING THE SUPPORT AND ASSISTANCE AS NEEDED.

C. STUDY THE EFFECT OF AUXILIARY HEALTH PROFESSIONALS GAINING HOSPITAL PRIVILEGES IN THE PRACTICE OF MEDICINE AS WELL AS THEIR IMPACT ON THE COST OF MEDICAL CARE.

D. ENCOURAGE COUNTY HOSPITAL MEDICAL STAFF COMMITTEES' PARTICIPATION IN THE FMA COUNCIL ON HMS AND THE AMA HMSS.

E. DEVELOP A PROGRAM THAT WOULD IMPROVE THE HOSPITAL MEDICAL STAFF VOICE IN HOSPITAL PLANNING.

F. INFORM THE MEMBERSHIP OF ACTIVITIES OF THE COUNCIL ON A QUARTERLY BASIS IN CONJUNCTION WITH THE BOARD OF GOVERNORS MEETING THROUGH A COUNCIL ON HOSPITAL MEDICAL STAFFS' NEWSLETTER.

LONG-TERM GOALS

A. STUDY THE CHANGING MEDICAL CARE ENVIRONMENT AND ITS POTENTIAL EFFECT ON HOSPITAL MEDICAL STAFFS AND ORGANIZED MEDICINE.
B. DEVELOPMENT OF SERVICES NECESSARY TO STRENGTHEN HOSPITAL/HEALTH FACILITY MEDICAL STAFFS.
C. TO INCREASE AWARENESS OF ISSUES THAT ARE AFFECTING PHYSICIANS AS MEMBERS OF MEDICAL STAFFS.
D. TO PROVIDE AN AVENUE FOR HOSPITAL MEDICAL STAFFS TO HAVE ACCESS TO THE POLICYMAKING BODY OF THE FMA.

Local County Hospital Medical Staffs Committees: The Board encouraged county medical societies to establish local county medical society/hospital medical staff committees composed of elected representatives from medical staffs of all hospitals within the county's jurisdiction.

Local County Hospital Medical Staffs: The Board recommended to county medical societies that each member of the local hospital medical staff committee be an elected member from his/her medical staff serving a two-year term; and further, that he/she be eligible for privileges of the floor in the two Council Hospital Medical Staff statewide meetings held annually.

Slide Presentation: The Board approved the development of a slide presentation for the purpose and development of the Council on Hospital Medical Staffs for use as an educational tool by county medical societies and hospital medical staffs.

Quarterly Newsletter: The Board approved the publication of a quarterly newsletter on Hospital Medical Staffs' activities to be disseminated to county medical societies and local hospital medical staffs.

Risk Management Committee: The Board approved the establishment of a Risk Management Committee under the purview of the Council to identify and develop an educational program to address this issue.

Participation in Statewide Hospital Medical Staff Meetings: The Board approved the recommendation that participation in the Council on Hospital Medical Staffs bi-annual meetings be limited to those delegates who are elected by hospital medical staffs or county chairmen of local hospital medical staff committees who will have the privilege of the floor at these meetings.



Gathered for the presentation of the AMA-ERF checks were the three deans of Florida medical schools. Left to right: Bernard J. Fogel, M.D., University of Miami School of Medicine, Miami; Andor Szentivanyi, M.D., University of South Florida College of Medicine, Tampa; William B. Deal, M.D., University of Florida College of Medicine, Gainesville.

AMA Bylaws Change: The Board approved the recommendation that the FMA pursue through AMA channels an amendment to allow the state chairmen of state hospital medical staff organizations to be delegates in their own right to the AMA Hospital Medical Staff Section.

RESOLUTION 85-2
Alternative Delivery Systems
Duval County Medical Society

The motion of the Reference Committee to refer Resolution 85-2 to the Board of Governors carried.

RESOLUTION 85-2

Alternative Delivery Systems

(Referred to Board of Governors)

Whereas, Tremendous emphasis is being placed on alternative delivery systems by government and business leaders; and

Whereas, An increasing number of patients are becoming confused as to what these alternative systems will do for them; and

Whereas, The traditional patient-personal physician relationship is being seriously eroded; and

Whereas, The Florida Medical Association membership needs to be kept informed regarding these systems and how it can effectively compete against them; therefore be it

RESOLVED, That the Florida Medical Association place more emphasis on providing information to its membership regarding alternative health delivery systems and develop a strategy and plan of action that can be used by physicians individually or collectively in competing with said systems; and be it further

RESOLVED, That funding and staffing be added to bring this program into fruition as soon as possible.

RESOLUTION 85-4
Workers' Compensation Medical Fee Schedule
Dade County Medical Association

A Substitute Resolution 85-4 was offered by the Reference Committee and its adoption moved. The motion carried and Substitute Resolution 85-4 was adopted.

SUBSTITUTE RESOLUTION 85-4
Workers' Compensation Medical Fee Schedule

RESOLVED, That legislation revising the workers' compensation reimbursement system be sponsored by FMA and be given a high priority; and be it further

RESOLVED, That the FMA immediately retain expert legal counsel knowledgeable about the workers' compensation laws, for purposes of legal or other actions against the appropriate party or parties to accomplish the goals of Resolution 83-7; and be it further

RESOLVED, That all county medical societies be informed of the progress and status of this situation on a timely basis.

RESOLUTION 85-6
1986 Relative Value Study
Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 85-6 was not adopted.

RESOLUTION 85-22
Competition in Medicine
Palm Beach County Medical Society

A Substitute Resolution 85-22 was offered by the Reference Committee and its adoption was moved. The motion carried and Substitute Resolution 85-22 was adopted.

SUBSTITUTE RESOLUTION 85-22
Competition in Medicine

RESOLVED, That the Florida Medical Association's AMA Delegation submit a resolution to the American Medical Association urging the Congress and the President to end the mandate requiring employers to offer an HMO system, and be it further

RESOLVED, That the Florida Medical Association urge the Florida Congressional Delegation to also seek an end to the mandate requiring employers to offer an HMO option.

The Reference Committee expressed gratitude to all FMA members and staff who appeared before the Committee.

The Reference Committee Chairman expressed that he was fortunate to work with a most efficient and informed Committee, John M. Canakaris, M.D., Robert L. Dawson, M.D., Alan J. Yesner, M.D., Charles B. McIntosh, M.D., Miguel Figueroa, M.D., Ralph E. Rydell, M.D., Jack W. MacDonald, M.D, and AMA Delegate Joseph C. Von Thron, M.D., AMA Alternate Delegate Dick L. Van Eldik, M.D., and also expressed his appreciation to Richard S. Hodes, M.D., Chairman of the Council on Medical Economics and T.M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs for their outstanding effort on behalf of FMA members this past year.

The Reference Committee also thanked Mrs. Lynn Mobarak, Mr. E. Russell Jackson, and Mr. Robert W. Seligson for their able assistance in the preparation of the report.

The motion of the Reference Committee that the Report of the Reference Committee No. V, Medical Economics, be adopted as amended carried.



The 1985-86 Florida Medical Association Board of Governors poses for the first time after the final session of the House of Delegates. Seated (left to right): Past President J. Lee Dockery, M.D., Gainesville; President-Elect James B. Perry, M.D., Ft. Lauderdale; Treasurer Yank D. Coble Jr., M.D., Jacksonville; Vice President James G. White, M.D., Ormond Beach; President and Chairman Luis M. Perez, M.D., Sanford; Immediate Past President Frank C. Coleman, M.D., Tampa; Secretary Henry M. Yonge, M.D., Pensacola. Standing (left to right): Donald C. Jones, FMA Executive Director; Speaker of the House Guy T. Selander, M.D., Jacksonville; Kay K. Hanley, M.D., Clearwater; Robert N. Webster, M.D., Tallahassee; Charles K. Donegan, M.D., St. Petersburg; Charles B. McIntosh, M.D., Jacksonville; Gerold L. Schiebler, M.D., Gainesville; Dick L. Van Eldik, M.D., Lake Worth; A. Frederick Schild, M.D., Miami; Miss Jane A. Daniel, Student Member; Eugene G. Peek Jr., M.D., Ocala.



FMA President Frank C. Coleman, M.D., received recognition from the Florida Society of Pathologists. Dr. Glenn S. Hooper, Florida Society of Pathologists President, presents a plaque.

Dr. Perry then recognized Dr. Glenn S. Hooper, President of the Florida Society of Pathologists, who requested the privilege to speak to the House. Dr. Hooper presented from the lecturn to Dr. Coleman an expression of recognition for Dr. Coleman's outstanding service as President of the Florida Medical Association on behalf of the Florida Society of Pathologists.

Dr. Perry then recognized Dr. Perez who announced the members of the Board of Governors who had been either appointed or elected:

FMA Board of Governors

Luis M. Perez, M.D., President and Chairman
James B. Perry, M.D., President-Elect
James G. White, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
Frank C. Coleman, M.D., Immediate Past President
J. Lee Dockery, M.D., Past President
Guy T. Selander, M.D., Speaker of the House
Charles K. Donegan, M.D., AMA-86
Charles B. McIntosh, M.D., AL-86
Gerold L. Schiebler, M.D., M.D., A-86
Kay K. Hanley, M.D., B-87
Dick L. Van Eldik, M.D., C-89
A. Frederick Schild, M.D., D-88
Robert N. Webster, M.D., SBME-86
Eugene G. Peek Jr., M.D., HRS-86
Miss Jane A. Daniel, Student Member (UM)

The appointments of Council chairmen were also announced:

Judicial Council — Joseph H. Davis, M.D.
Council on Legislation — Louis C. Murray, M.D.
Council on Medical Services — Joseph T. Ostroski, M.D.
Council on Scientific Activities — Pierre J. Bouis Jr., M.D.
Council on Specialty Medicine — William T. Hawkins, M.D.
Council on Hospital Medical Staffs — T.M. "Dan" Daniel, M.D.
Council on Medical Economics — Richard S. Hodes, M.D., and Charles P. Hayes, M.D., Co-Chairmen

Dr. Perry then called Dr. Alvin E. Smith to the podium for the benediction

The 1985 House of Delegates adjourned at 11:20 a.m.

Florida Medical Association, Inc. Officers, Councils and Committees 1985 - 1986

OFFICERS

Luis M. Perez, M.D., President Sanford
James B. Perry, M.D., President-Elect . . . Ft. Lauderdale
James G. White, M.D., Vice President . . Ormond Beach
Guy T. Selander, M.D., Speaker of House . . Jacksonville
Arthur L. Eberly Jr., M.D., Vice Speaker . Lighthouse Pt.
Henry M. Yonge, M.D., Secretary Pensacola
Yank D. Coble Jr., M.D., Treasurer Jacksonville
Frank C. Coleman, M.D., Imm. Past Pres. Tampa
Mr. Donald C. Jones, Exec. Vice Pres. Jacksonville

BOARD OF GOVERNORS

*Luis M. Perez, M.D., President Sanford
*James B. Perry, M.D., President-Elect . . . Ft. Lauderdale
*James G. White, M.D., Vice President . . Ormond Beach
*Henry M. Yonge, M.D., Secretary Pensacola
*Yank D. Coble Jr., M.D., Treasurer Jacksonville
J. Lee Dockery, M.D., PP-86 Gainesville
*Frank C. Coleman, M.D., IPP-87 Tampa
Guy T. Selander, M.D., Speaker of House . . Jacksonville
Charles B. McIntosh, M.D., AL-86 Jacksonville
Gerold L. Schiebler, M.D., A-86 Gainesville
**Kay K. Hanley, M.D., B-87 Clearwater
A. Frederick Schild, M.D., D-88 Miami
Dick L. Van Eldik, M.D., C-89 Lake Worth
Eugene G. Peek Jr., M.D., HRS-86 Ocala
Charles K. Donegan, M.D., AMA DEL-86 St. Petersburg
Robert N. Webster, M.D., SBME-86 Tallahassee
Jane Ailene Daniel, Student Mem-87 Miami

*Exec. Comm.
**Public Relations Officer

Liaison with Florida Osteopathic Medical Association
Louis C. Murray, M.D. Orlando
Liaison with Florida Bar
Charles J. Kahn, M.D. Pensacola
Liaison with Blue Cross and Blue Shield of Florida, Inc.
James B. Perry, M.D. Ft. Lauderdale
FLAMPAC
Robert E. Windom, M.D. Sarasota

COMMITTEES OF THE BOARD

COMMITTEE ON WOMEN PHYSICIANS

Myrna Catalina B. Ginter, M.D., Chairman Jacksonville
Nelita R. Ano, M.D. South Daytona
Linda Ann Marraccini, M.D. South Miami
Annette C. Barnes, M.D. Bartow
Gerold L. Schiebler, M.D., Liaison, Bd. of Gov. Gainesville
Margaret C. S. Skinner, M.D., Liaison, Comm. Mem. Dev. . Miami

COMMITTEE ON BYLAWS

James B. Perry, M.D., Chairman Ft. Lauderdale
Kay K. Hanley, M.D. Clearwater
Yank D. Coble Jr., M.D. Jacksonville
Sanford A. Mullen, M.D. Jacksonville
Henry M. Yonge, M.D. Pensacola

COMMITTEE ON FUTURE ACTIVITIES

Frank C. Coleman, M.D., Chairman Tampa
John Patrick Hanley, M.D. Clearwater
Robert E. Boyett, M.D. Miami
Daniel B. Nunn, M.D. Jacksonville
Robert John Brueck, M.D. Ft. Myers
William B. Deal, M.D. Gainesville
James Wilson Bridges, M.D. Miami
Chester D. Miltenberger, M.D. Sanford

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Charles K. Donegan, M.D., Chairman St. Petersburg
James B. Perry, M.D. Ft. Lauderdale
Sanford A. Mullen, M.D. Jacksonville
Mrs. David S. (Sandra) Whittaker Ocala
Charles B. McIntosh, M.D. Jacksonville
Margaret C. S. Skinner, M.D. Miami
Robert E. Windom, M.D. Sarasota
Scott B. Baker, M.D. Jacksonville

FLORIDA AMA DELEGATES

Charles K. Donegan, M.D., Chm. Delegate Seat #3 St. Petersburg
(Term expires 12/31/86)
†Lee A. Fischer, M.D., Alternate Seat #3 . . . West Palm Beach
(Term begins 1/1/86; expires 12/31/86)
Joseph C. Von Thron, M.D., V. Chm., Del. Seat #7 . Cocoa Beach
Charles A. Dunn, M.D., Alternate Seat #7 Miami
(Terms expire 12/31/87)
Joseph T. Ostroski, M.D., Delegate Seat #2 Miami
James B. Perry, M.D., Alternate Seat #2 Ft. Lauderdale
(Terms expire 12/31/86)
T. Byron Thames, M.D., Delegate Seat #1 Orlando
(Term expires 12/31/87)
††Daniel L. Seckinger, M.D., Alternate Seat #1 Miami
(Term begins 1/1/86; expires 12/31/87)

†††Frank C. Coleman, M.D., Delegate Seat # 4 Tampa
(Term begins 1/1/86; expires 12/31/87)
Eugene G. Peek Jr., M.D., Alternate Seat #4 Ocala
(Term expires 12/31/87)
Richard G. Connar, M.D., Delegate Seat #5 Tampa
Vernon B. Astler, M.D., Alternate Seat #5 Boynton Beach
(Terms expire 12/31/86)
Charles J. Kahn, M.D., Delegate Seat #6 Pensacola
O. William Davenport, M.D., Alternate Seat #6 Miami
(Terms expire 12/31/87)
Louis C. Murray, M.D., Delegate Seat #8 Orlando
J. Lee Dockery, M.D., Alternate Seat #8 Gainesville
(Terms expire 12/31/87)
Robert E. Windom, M.D., Delegate Seat #9 Sarasota
Kay K. Hanley, M.D., Alternate Seat #9 Clearwater
(Terms expire 12/31/86)
Luis M. Perez, M.D., Delegate Seat #10 Sanford
Arthur L. Eberly, M.D., Alternate Seat #10 Lighthouse Pt.
(Terms expire 12/31/86)
Sanford A. Mullen, M.D., Delegate Seat #11 Jacksonville
Dick L. Van Eldik, Alternate Seat #11 Lake Worth
(Terms expire 12/31/86)

†Frank C. Coleman, M.D. to serve as Alternate for Seat #3 until 12/31/85
††Vincent P. Corso, M.D. to serve as Alternate Delegate for Seat #1 until 12/31/85
†††Eugene G. Peek, M.D. to serve as Delegate for Seat #4 until 12/31/85

BOARD OF PAST PRESIDENTS

Joseph C. Von Thron, M.D., 1973, Chairman Cocoa Beach
Frank C. Coleman, M.D., 1984, Secretary Tampa
Duncan T. McEwan, M.D., 1954 Orlando
Jere W. Annis, M.D., 1958 Lakeland
Leo M. Wachtel, M.D., 1960 Jacksonville
Samuel M. Day, M.D., 1964 Jacksonville
H. Phillip Hampton, M.D., 1965 Tampa
George S. Palmer, M.D., 1966 Tallahassee
W. Dean Steward, M.D., 1967 Marianna
Henry J. Babers Jr., M.D., 1969 Gainesville
James T. Cook Jr., M.D., 1970 Marianna
Floyd K. Hurt, M.D., 1971 Jacksonville
William J. Dean, M.D., 1972 St. Petersburg
Thad Moseley, M.D., 1974 Jacksonville
Vernon B. Astler, M.D., 1975 Boynton Beach
Jack A. MaCris, M.D., 1976 St. Petersburg
Louis C. Murray, M.D., 1977 Orlando
O. William Davenport, M.D., 1978 Miami
Richard S. Hodes, M.D., 1979 Tampa
T. Byron Thames, M.D., 1980 Orlando
Sanford A. Mullen, M.D., 1981 Jacksonville
Robert E. Windom, M.D., 1982 Sarasota
J. Lee Dockery, M.D., 1983 Gainesville

FMA SPEAKERS BUREAU

Edward R. Annis, M.D., Chairman Miami Shores
Kay K. Hanley, M.D. Clearwater
J. Lee Dockery, M.D. Gainesville
Donald G. Nikolaus, M.D. Dunedin
Richard S. Hodes, M.D. Tampa

COUNCIL ON LEGISLATION

Louis C. Murray, M.D., Chairman Orlando

NATIONAL LEGISLATION

Louis C. Murray, M.D., Chairman Orlando
Jere W. Annis, M.D. Lakeland
Joe B. Harbison, M.D. Panama City
James G. White, M.D. Ormond Beach
William J. Broussard, M.D. Melbourne
David C. Albritton, M.D. Ocala
John M. Hamilton, M.D. St. Petersburg
Irving M. Essrig, M.D. Tampa
Samuel M. Day, M.D. Jacksonville
Robert E. Windom, M.D. Sarasota
Julian H. Groff, M.D. N. Miami Beach
William F. Eckbert, M.D. Winter Park
William W. Atkinson, M.D. Tarpon Springs
Margaret C. S. Skinner, M.D. Miami
Warren Lindau, M.D. Miami
H. Quillian Jones Jr., M.D. Fort Myers
Reginald J. Stambaugh, M.D. West Palm Beach
James B. Perry, M.D. Ft. Lauderdale
John W. Glotfelty, M.D. Lakeland
V. A. Marks, M.D. Palm Beach Gardens
Stanley I. Margulies, M.D. Hollywood
Laurie L. Dozier Jr., M.D. Tallahassee

STATE LEGISLATION

Thomas P. Wood, M.D., Chairman Tallahassee
Mathis Becker, M.D. Plantation
Thomas M. Daniel, M.D. Clearwater
Eric F. Geiger, M.D. Pensacola
Charles J. Kahn, M.D. Pensacola
Jerry D. Moore, M.D. Pompano Beach
Michael J. Pickering, M.D. Tampa
Virgil A. Ponzoli Jr., M.D. Naples
Ernest G. Sayfie, M.D. Hollywood
Margaret C. S. Skinner, M.D. Miami
Alvin E. Smith, M.D. Ormond Beach
Mrs. Stephen S. (Carolyn) Spore DeLand

COUNCIL ON MEDICAL ECONOMICS

Richard S. Hodes, M.D., Co-Chairman Tampa
Charles P. Hayes Jr., M.D., Co-Chairman Jacksonville

COMMITTEE ON HEALTH CARE DELIVERY

William J. Garoni Jr., M.D., Chairman Jacksonville
James K. Conn, M.D. Tallahassee
Jack W. MacDonald, M.D. Tallahassee
Thomas E. McKell, M.D. Tampa
Linda A. Marraccini, M.D. South Miami

SUBCOMMITTEE ON BUSINESS COALITION

Thomas E. McKell, M.D., Chairman Tampa
Spurgeon W. McWilliams, M.D. Tallahassee
William P. Booras, M.D. Jacksonville
Charles A. Dunn, M.D. Miami
Edward L. Farrar, M.D. Orlando

SUBCOMMITTEE ON GOVERNMENT PROGRAMS

James K. Conn, M.D., Chairman Tallahassee
John N. Carlson, M.D. Sarasota
Frank B. Hodnette, M.D. Pensacola
Donald G. Nikolaus, M.D. Dunedin
John F. McGarry, M.D. Orlando
Ernest G. Sayfie, M.D. Hollywood

SUBCOMMITTEE ON HEALTH CARE FINANCING ALTERNATIVE DELIVERY MECHANISMS

Jack W. MacDonald, M.D., Chairman Tallahassee
William P. Booras, M.D. Jacksonville

Manuel L. Carbonell, M.D. Miami
Edward L. Farrar, M.D. Orlando
Gerald L. Stoker, M.D. Tampa
David A. Johnson, M.D. Zephyrhills

COMMITTEE ON RELATIVE VALUE STUDIES

Joel W. Mattison, M.D., Chairman Tampa
Charles K. Donegan, M.D., Vice Chairman St. Petersburg
John C. Fletcher, M.D. Tampa
Herbert D. Kerman, M.D. Daytona Beach
Daniel L. Seckinger, M.D. Miami
Jimmie D. Moore, M.D. Orlando
Richard W. Snodgrass, M.D. Daytona Beach
George A. Richard, M.D. Gainesville
John T. Johnson, M.D. Sanford

COMMITTEE ON WORKERS' COMPENSATION

Howard A. Kurzner, M.D., Chairman Miami
Benjamin A. Johnson, M.D. Jacksonville
Bernard L. Morgan, M.D. Jacksonville
Charles K. Donegan, M.D. St. Petersburg
Howard P. Hogshead, M.D. Jacksonville

COMMITTEE ON PEER REVIEW ORGANIZATIONS (PRO)

Paul J. Popovich, M.D., Chairman Melbourne
A. Raymond Brooker Jr., M.D. Tampa
Charles A. Dunn, M.D. Miami
Arthur L. Eberly Jr., M.D. Lighthouse Point
Charles W. Lewis, M.D. Jacksonville
Thomas D. Bartley, M.D. Gainesville

COUNCIL ON MEDICAL SERVICES

Joseph T. Ostroski, M.D., Chairman Miami

EMERGENCY MEDICAL SERVICES

Daniel E. Lucas, M.D., Chairman Stuart
H. Quillian Jones Jr., M.D. Ft. Myers
H. Wayne Lee, M.D. Ft. Lauderdale
H. Stewart Siddall, M.D. Tampa
James L. Talbert, M.D. Gainesville
Raymond H. Alexander, M.D., HRS Liaison Mem. Gainesville

COMMITTEE ON AGING

Eric A. Pfeiffer, M.D., Chairman Tampa
George J. Caranasos, M.D. Gainesville
Joseph Harris, M.D. Miami Beach
Donald G. Nikolaus, M.D. Dunedin
James N. Sussex, M.D. Miami
Mrs. Fred P. (Anne) Swing Charlotte Harbor
Alan B. Grindal, M.D. Sarasota

COMMITTEE ON SUBSTANCE ABUSE

Joseph H. Deatsch, M.D., Chairman Jacksonville
John S. Flint, M.D. St. Petersburg
John C. Eustace, M.D. Miami Beach
Donn L. Smith, M.D. Tampa
Mrs. C. B. (Nancy) Miles Pompano Beach

COMMITTEE ON SCHOOL HEALTH

Bernard Kimmel, M.D., Chairman West Palm Beach
Rupert E. Arnell, M.D. Miami Lakes
Richard J. Boothby, M.D. Jacksonville
Joseph E. Holland, M.D. Leesburg
Hector R. Mendez, M.D. Orlando
James J. Townsend, M.D. Jacksonville
Linda Ann Marraccini, M.D. South Miami

COMMITTEE ON PUBLIC HEALTH

Robert D. May, M.D., Chairman New Port Richey
Clarence L. Brumback, M.D. West Palm Beach
Patricia C. Cowdery, M.D. Jacksonville
R. Edward Dodge Jr., M.D. Inverness
Donald S. Kwalick, M.D. Tampa
Jorge DeJu, M.D. Longwood
E. Charlton Prather, M.D. Tallahassee

COMMITTEE ON VOLUNTARY HEALTH AGENCIES AND ALLIED HEALTH

William W. Thompson, M.D., Chairman Ft. Walton Beach
William A. Sodeman Jr., M.D. Tampa
Jay S. Skyler, M.D. Miami
Jack W. MacDonald, M.D. Tallahassee
Charles P. Hayes Jr., M.D. Jacksonville
Laurin G. Smith, M.D. Vero Beach
George A. Gant, M.D. Kissimmee

COUNCIL ON SCIENTIFIC ACTIVITIES

Pierre J. Bouis Jr. M.D., Chairman Tampa

COMMITTEE ON MEDICAL EDUCATION

Orris O. Rollie, M.D., Chairman Orlando
George A. Bishopric, M.D. Sarasota
Anthony P. Garritano, M.D. Largo
Charles W. Hilton, M.D. Pensacola
William B. Deal, M.D. Gainesville
Bernard J. Fogel, M.D. Miami
Ira B. Harrison, M.D. Tallahassee
David S. Hubbell, M.D. St. Petersburg
Jeno E. Szakacs, M.D. Tampa
Andor Szentivanyi, M.D. Tampa

COMMITTEE ON SCIENTIFIC PUBLICATIONS

Remigio G. Lacsamana, M.D., Editor Daytona Beach
Gerold L. Schiebler, M.D., Liason Bd. of Gov. Gainesville

COUNCIL ON HOSPITAL MEDICAL STAFFS

T. M. "Dan" Daniel, M.D., Chairman Clearwater
R. W. Cunningham, M.D. Gainesville
M. S. Freedman, M.D. Hudson
R. F. Barnes, M.D. Bartow
L. A. Erdman, M.D. Ft. Lauderdale
R. W. Snodgrass, M.D. Daytona Beach
Joseph Harris, M.D. Miami Beach
Esteban Valdes-Castillo, M.D. Miami
Robert P. Johnson, M.D. Tallahassee

COMMITTEE ON RISK MANAGEMENT

Raymond F. Barnes, M.D., Chairman Bartow
Charles P. Gibbs, M.D. Gainesville
Francis L. Howington, M.D. Fort Myers
Howard P. Hogshead, M.D. Jacksonville
Paul A. Gluck, M.D. Miami
Hubert A. Aronson, M.D. Miami

COUNCIL ON SPECIALTY MEDICINE

William T. Hawkins, M.D., Chairman Gainesville

Florida Allergy and Immunology Society
Melvin Newman, M.D. Jacksonville
Florida Society of Anesthesiologists
Jimmie D. Moore, M.D. Orlando
Florida Chapter, American College of Chest Physicians
W. Michael Alberts, M.D. Tampa
Florida Society of Colon and Rectal Surgeons
Harvey A. Shub, M.D. Orlando
Florida Society of Dermatology
Clifford Lober, M.D. Altamonte Springs
Florida Chapter, American College of Emergency Physicians
Fredric C. Wurtzel, M.D. Maitland
Florida Endocrine Society
Amid Habib, M.D. Altamonte Springs
Florida Academy of Family Physicians
Charles A. Dunn, M.D. Miami
Florida Gastroenterologic Society
Jan S. Hirschfield, M.D. Clearwater
Florida Society of Internal Medicine
Fred S. Carter, M.D. Jensen Beach
Florida Society of Neonatal Perinatologists
Thomas Chiu, M.D. Tampa
Florida Society of Nephrology
Thomas C. Marbury, M.D. Orlando
Florida Society of Neurology
John S. Scott, M.D. Orlando
Florida Neurosurgical Society
David C. Lane, M.D. Ft. Lauderdale
Florida Association of Nuclear Physicians
Warren R. Janowitz, M.D. Miami Beach
Florida Obstetric and Gynecologic Society
Robert T. Hoover, M.D. Winter Park
Florida Occupational Medical Association
R. Than Myint, M.D Tampa
Florida Society of Clinical Oncologists
Alan H. Porter, M.D. Sarasota
Florida Society of Ophthalmology
Maurice M. Berger, M.D. Leesburg
Florida Orthopedic Society
William J. Hutchison, M.D. Tallahassee
Florida Society of Otolaryngology — Head and Neck Surgery
Robert K. Middlekauff, M.D. Jacksonville
Florida Society of Pathologists
Joseph H. Keffer, M.D. Miami Beach
Florida Chapter, American Academy of Pediatrics and Florida Pediatric Society
George A. Richard, M.D. Gainesville
Florida Association of Pediatric Cardiologists
Ira H. Gessner, M.D. Gainesville
Florida Association of Pediatric Surgeons
Ronald F. David, M.D. Orlando
Florida Society of Physical Medicine and Rehabilitation
Richard A. Chidsey, M.D. Jupiter
Florida Region, American College of Physicians
David A. Giordano, M.D. Sarasota
Florida Society of Plastic and Reconstructive Surgery
Alan S. Rapperport, M.D. Plantation Key
Florida Society for Preventive Medicine
E. Charlton Prather, M.D. Tallahassee
Council of Florida District Branches, American Psychiatric Association
McKinley Cheshire, M.D. West Palm Beach
Florida Radiological Society
W. Thomas Hawkins, M.D. Gainesville
Florida Society of Rheumatology
Louis M. Sales, M.D. Jacksonville
Florida Chapter, American College of Surgeons
John C. Fletcher, M.D. Tampa
Florida Association of General Surgeons
Theron T. Knight, M.D. Lehigh Acres
Florida State Surgical Division, International College of Surgeons
Robert H. Hux, M.D. Leesburg
Florida Society of Thoracic and Cardiovascular Surgeons
Franklin G. Norris, M.D. Orlando
Florida Thoracic Society
Robert C. Snyder, M.D. Orlando
Florida Urological Society
Manuel J. Coto, M.D. Orlando

JUDICIAL COUNCIL

Joseph H. Davis, M.D., D-87, Chairman Miami
O. Frank Agee, M.D., A-90 Gainesville
Kenneth C. Kiehl, M.D., B-89 Sarasota
Robert J. Brennan, M.D., C-88 Ft. Lauderdale
Maurice H. Laszlo, M.D., AL-86 N. Miami Beach

MEMBERSHIP AND DISCIPLINE

District 1 — Lealis L. Hale Jr., M.D., 86 Ft. Walton Beach
James T. Cook III, M.D., 87 Panama City
Robert C. Palmer, M.D., 88 Pensacola
Rufus Thames, M.D., 89 Milton

District 2 — James K. Conn, M.D., 86 Tallahassee
Robert P. Johnson, M.D., 87 Tallahassee
James T. Cook Jr., M.D., 88 Marianna
Herbert E. Brooks, M.D., 89 Bonifay

District 3 — Samuel J. Alford Jr., M.D., 86 Jacksonville
Hugh A. Carithers, M.D., 87 Jacksonville
John A. Rush, M.D., 88 Jacksonville
Joe C. Ebbinghouse, M.D., 89 Jacksonville

District 4 — Harry F. Farmer, M.D., 86 New Smyrna Beach
Charles E. Barrineau, M.D., 87 Palatka
Richard W. Snodgrass, M.D., 88 Daytona Beach
Bruce R. Witten, M.D., 89 St. Augustine

District 5 — Jorge A. Gomez, M.D., 86 Longwood
Calvin R. Peters, M.D., 87 Orlando
Clarence M. Gilbert, M.D., 88 Orlando
James E. Quinn, M.D., 89 Sanford

District 6 — J. Maxey Dell Jr., M.D., 86 Gainesville
W. Thomas Hawkins, M.D., 87 Gainesville
David A. Johnson, M.D., 88 Zephyrhills
Wilburn R. Jenkins, M.D., 89 Inverness

District 7 — J. Robert Qualey, M.D., 86 Tampa
Linus W. Hewit, M.D., 87 Tampa
William B. Hopkins, M.D., 88 Tampa
Jeff W. Harris, M.D., 89 Tampa

District 8 — James C. Fleming, M.D., 86 Clearwater
William E. Hale, M.D., 87 Dunedin
John T. Karaphillis, M.D., 88 Clearwater
Royce Hobby, M.D., 89 St. Petersburg

District 9 — Ross. G. Olson, M.D., 86 New Pt. Richey
Paul G. Winquist, M.D., 87 New Pt. Richey
Joseph P. Levine, M.D., 88 Tampa
Bettie R. Drake, M.D., 89 Tampa

District 10 — Thomas R. Busard, M.D., 86 Bradenton
William Allen Boyce, M.D., 87 Bradenton
Wiley E. Koon, M.D., 88 Winter Haven
James D. Morgan, M.D., 89 Winter Haven

District 11 — Francis S. Pooser, M.D., 86 Melbourne
David Tingle, M.D., 87 Gainesville
John O. Rao, M.D., 88 Kissimmee
Enoch J. Vann, M.D., 89 Vero Beach

District 12 — Fred S. Carter, M.D., 86 Jensen Beach
V. A. Marks, M.D., 87 Palm Beach Gardens
Robert Burger, M.D., 88 Lake Worth
Reginald J. Stambaugh, M.D., 89 W. Palm Bch.

District 13 — Joseph P. O'Bryan, M.D., 86 Ft. Myers
Richard C. Rehmeyer, M.D., 87 Sarasota
David L. Thomas, M.D., 88 Venice
Martin F. Mihm, M.D., 89 Sarasota

District 14 — E. Joan Barice, M.D., 86 Singer Island
Lee A. Fischer, M.D., 87 West Palm Beach
William J. Romanos Jr., M.D., 88 N. Palm Bch.
James F. Smith, M.D., 89 West Palm Beach

District 15 — Peter A. Tomasello, M.D., 86 Plantation
Stanley S. Goodman, M.D., 87 Plantation
Wayne G. Riskin, M.D., 88 Hollywood
Robert J. Brennan, M.D., 89 Ft. Lauderdale

District 16 — Leon Talan, M.D., 86 Miami
William C. Hartley, M.D., 87 Hollywood
Nestor C. Guaty, M.D., 88 Miami
Jose F. Landa-Gutierrez, M.D., 89 Miami

District 17 — Charles A. Monnin Jr., M.D., 87 Hialeah
Richard C. Clay, M.D.,88 Miami
Maurice H. Laszlo, M.D., 89 N. Miami Beach

District 18 — Sheldon Zane, M.D., 86 N. Miami Beach
Everett Shocket, M.D., 87 Miami Beach
Jerome Benson, M.D., 88 Miami Beach
Richard M. Fleming, M.D., 89 Miami Beach

District 19 — Norman Gottlieb, M.D., 86 Coral Gables
John D. White, M.D., 87 Tavernier
Rufus K. Broadaway, M.D., 88 Miami
Linda Ann Marraccini, M.D., 89 South Miami

FLORIDA MEDICAL FOUNDATION

James B. Perry, M.D., President Ft. Lauderdale
Dick L. Van Eldik, M.D., Vice President Lake Worth
Henry M. Yonge, M.D., Vice President Pensacola
James G. White, M.D., Vice President Ormond Beach
Yank D. Coble Jr., M.D., Secretary-Treasurer Jacksonville

CONTINUING MEDICAL EDUCATION

Robert H. Threlkel, M.D., Chairman Jacksonville
Robert E. Cline, M.D. Ft. Lauderdale
Yank D. Coble Jr., M.D. Jacksonville
Eugene T. Davidson, M.D. Lakeland
Arvey I. Rogers, M.D. Miami
Alvin E. Smith, M.D. Ormond Beach
Robert K. Wilson Jr., M.D. Pensacola

PEER MEDICAL UTILIZATION REVIEW

Kenneth C. Kiehl, M.D., Chairman Sarasota
John A. Dyal, M.D. Perry
Frank B. Hodnette, M.D. Pensacola
John T. Karaphillis, M.D. Clearwater
Milton E. Lesser, M.D. Miami Beach
Willard E. Manry, M.D. Lake Wales
Charles B. Mutter, M.D. Miami
Elwin G. Neal, M.D. Miami Shores
Benjamin C. Olliff, M.D. Jacksonville
Peter A. Tomasello, M.D. Plantation

IMPAIRED PHYSICIANS

Guy T. Selander, M.D., Chairman Jacksonville
Nelita R. Ano, M.D. South Daytona
John M. Butcher, M.D. Sarasota
Harold L. Ishler Jr., M.D. Clearwater
John F. Mason Jr., M.D. Panama City
Hector R. Mendez, M.D. Orlando
Arvey I. Rogers, M.D. Miami
Laurin G. Smith, M.D. Vero Beach
John E. Perchalski, M.D. Temple Terrace
Mrs. B. David (Edie) Epstein Key Biscayne
Dolores A. Morgan, M.D. Miami Beach
Roger Goetz, M.D., Advisory Member Jacksonville

FLORIDA MEDICAL ASSOCIATION AUXILIARY

Mrs. Milton R. (Jo) Tignor, President N. Palm Beach
Mrs. V. A. (Susan) Marks, President Elect N. Palm Beach
Mrs. David S. (Sandra) Whittaker, First Vice Pres. Ocala
Mrs. Arthur L. (Jane) Eberly Jr., Secretary Lighthouse Pt.
Mrs. James G. (Beebe) White, Treasurer Ormond Beach

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

Board of Directors

Robert E. Windom, M.D., President Sarasota
Frank C. Coleman, M.D., Imm. Past President Tampa
James G. White, M.D., Vice President Ormond Beach
Carlos G. Llanes, M.D., Secretary Miami
Louis C. Murray, M.D., Treasurer Orlando
Luis M. Perez, M.D. Sanford
H. Quillian Jones Jr., M.D. Fort Myers
Juan S. A. Wester, M.D. Hollywood
Mrs. Thomas M. (Marilyn) Caswall Lauderdale By The Sea
Dick L. Van Eldik, M.D. Lake Worth
Warren Lindau, M.D. Miami
Frank R. Wilkerson Jr., M.D. Ocala
William W. Thompson, M.D. Ft. Walton Beach
James W. Bridges, M.D. Miami
William J. Broussard, M.D. Melbourne
Thomas M. Caswall, M.D. Lauderdale By The Sea
Mrs. James H. (Nancy) Corwin Neptune Beach
T. M. "Dan" Daniel, M.D. Clearwater
Mrs. Arthur L. (Jane) Eberly, Jr. Lighthouse Point
Mrs. B. David (Edie) Epstein Key Biscayne
John W. Glotfelty, M.D. Lakeland
Kay K. Hanley, M.D. Clearwater
Stanley I. Margulies, M.D. Hollywood
Terence P. McCoy, M.D. Tallahassee
Richard B. Moore, M.D. West Palm Beach
Donald G. Nikolaus, M.D. Dunedin
Michael J. Pickering, M.D. Tampa
Margaret C. S. Skinner, M.D. Miami
Bruce P. Smith, M.D. Seminole
Alvin E. Smith, M.D. Ormond Beach
Paul W. Taylor, M.D. Vero Beach
Mrs. Milton R. (Jo) Tignor N. Palm Beach
H. Murray Todd, M.D. Ft. Lauderdale
Mr. Donald C. Jones, Assistant Treasurer Jacksonville

As of August 1985

FLORIDA PHYSICIANS ASSOCIATION, INC.

Charles J. Kahn, M.D., President Pensacola
John A. Dyal, M.D., Vice President Perry
Miguel Figueroa, M.D., Secretary N. Miami Beach
Warren M. Barrett, M.D., Treasurer Jacksonville
David T. Overbey, M.D., Imm. Past President St. Petersburg
James B. Perry, M.D., FMA Representative Ft. Lauderdale
Frank C. Coleman, M.D., FMA Representative Tampa
Luis M. Perez, M.D., FMA Representative Sanford
William W. Thompson, M.D., FLAMPAC Rep. Ft. Walton Beach

CERTIFIED PUBLIC ACCOUNTANTS

Harbeson Beckerleg & Fletcher Jacksonville

GENERAL COUNSEL

John E. Thrasher, Esq. General Counsel
Donald W. Weidner, Esq. Associate General Counsel



WANTED

Board Certified physicians or finishing residents in the following specialties who desire an attractive alternative to civilian practice:

NEUROSURGERY
ORTHOPEDIC SURGERY

Positions are available at both Army teaching facilities and community hospitals throughout the Southeastern United States.

Every Army physician is a commissioned officer. The Army offers a rewarding practice without the burdens of malpractice insurance premiums and other non-medical distractions.

Army medicine provides a reasonable salary while stressing a good clinical practice. Some positions offer teaching appointments in an affiliated status with nearby civilian medical schools or teaching programs. The Army might be just the right prescription for you and your family.

To obtain more information on eligibility, salary, and fringe benefits write or call collect:



AMEDD Personnel Counselor
3101 Maguire Boulevard
Essex Building, Suite 166
Orlando, Florida 32803
(305) 896-0780

A defense against cancer can be cooked up in your kitchen.



Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and



fish and types of sausages smoked by traditional methods should be eaten in moderation.

There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.

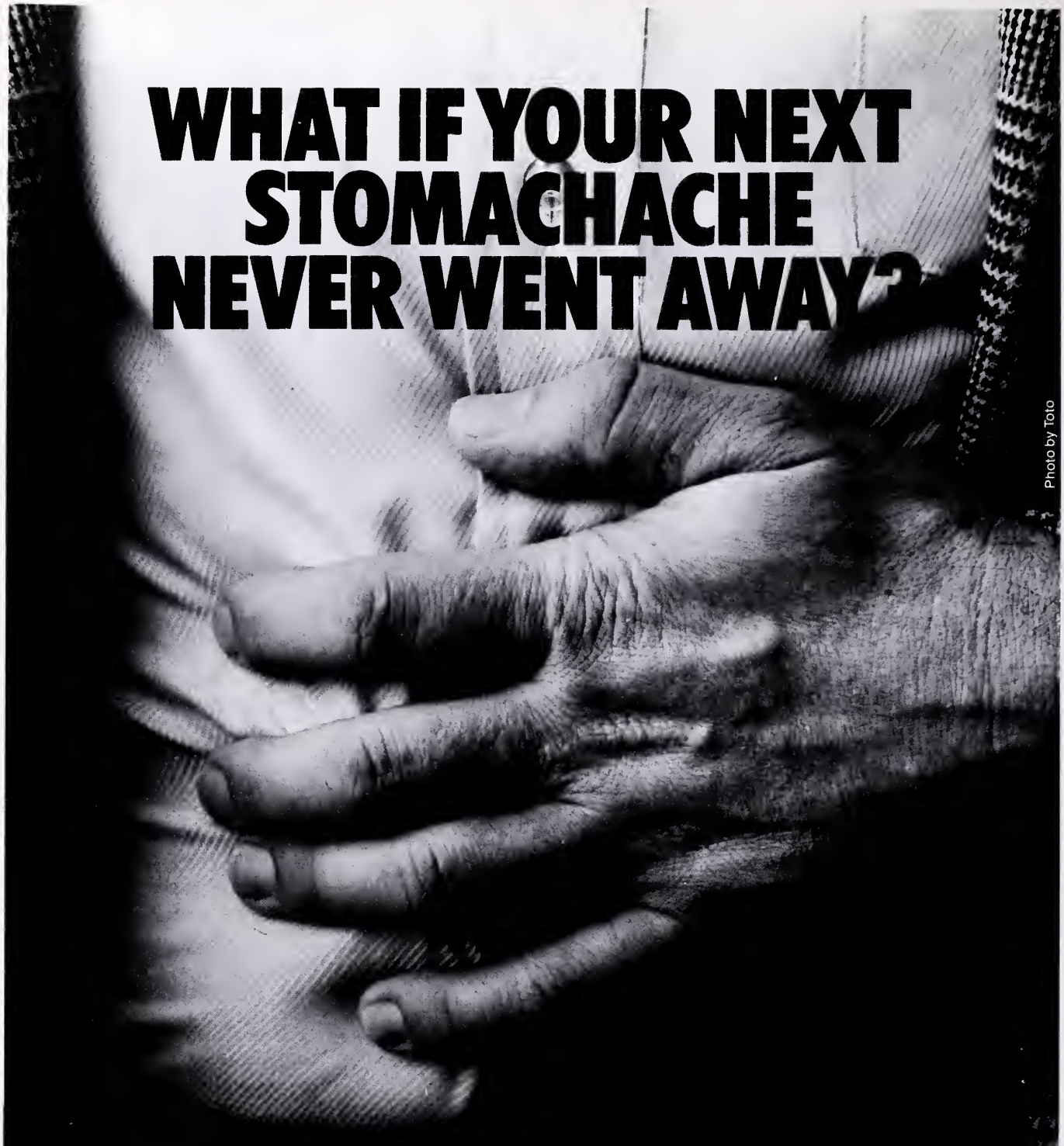


Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®



Imagine waking up with painful stomach cramps.

Imagine going through your day with terrible diarrhea.

Now imagine those painful, embarrassing symptoms never going away.

That's what people with Ileitis and Ulcerative Colitis endure every day.

Over 2 million men, women and children suffer with these devastating intestinal diseases. That's more than Muscular Dystrophy and Cerebral Palsy combined.

Yet as widespread as Ileitis and Ulcerative Colitis are, they're just as misunderstood.

Some people think these diseases are only in your mind. They're not.

Some people think they come from eating the wrong kinds of foods. They don't.

Some people even laugh at the symptoms. They shouldn't.

Because Ileitis and Ulcerative Colitis can strike at any age, at any time. And there's no known cause. Or cure.

If you can imagine yourself enduring this kind of pain, you know why we need your help.

And why we need it now.

The National Foundation for
Ileitis & Colitis

To send your tax-deductible contribution or for more information, please write: N.F.I.C., P.O. Box 2020, Murray Hill Station, New York, NY 10156

Indigent care: salvage the system or continue its carnage?

Twenty years after the Medicaid Act in 1965 yanked the responsibility of indigent care from the province of local physicians, community institutions, and volunteer groups, the government has reneged on its commitment and pruned its responsibility for health care for the poor. Within a short period of 90 days, the DRG system and federal cuts in Medicaid were proposed and imposed. The health care system had no time to evaluate or respond to such abrupt changes, and these alterations in reimbursment have forced many hospitals to restrict their indigent care. The stories we read about destitute patients being shifted from hospital to hospital where they are not wanted remind me of the wretches painted so dramatically in Gericault's "The Raft of the 'Medusa'". The medical indigent care system is about as desperate as the adrift individuals depicted on that raft.

The number of medically impecunious in the United States is immense and expanding: 35 million people lack health insurance of any type (an increase of 10 million since 1977) and another 22 million are enrolled in Medicaid. Medicaid patients in most states are not included among these uninsured figures, but the stingy Medicaid reimbursement schedule in Florida certainly consigns them to indigent status. Children constitute 46% of poor Americans and fewer than one third of them have any type of health insurance. The elderly, particularly those who cannot afford the increases in Medicare deductions, comprise 10-20% of our impoverished. In all, approximately one fourth of the nation's population is medically indigent.

We as physicians can approach the indigent problem several perspectives and have the following options: (I) We can ignore it; (II) We can besiege and beseech the legislatures to increase funding; (III) We can establish different tiers of health care delivery and relegate the indigent to a level of care less demanding on the physicians; or (IV) We can assume full responsibility and devise alternate, pluralistic approaches to the problem. I would like to explore these alternatives.

Option I: ignoring the problem • We can ignore it, continue business as usual, and hope that the problem will spontaneously resolve. Acceptance of this option is irrational for ethical, economic and political reasons.

Ethically, physicians have always committed their services to all who require them; repudiation of that obligation after 25 centuries is repugnant. Fortunately, most physicians — about 80% of the total — provide some free care.

Economically, the restriction of access by the poor to medical care today will increase society's cost for their care tomorrow. Lack of insurance in 1983 dissuaded 5 million patients from acquiring medical care and treatment. Investigations examining the ultimate price of such medical deprivation have been conducted. Several have demonstrated that one dollar's worth of prenatal care can save two to eleven dollars of services required by those infants of mothers who were denied prenatal care. Additionally, inadequate prenatal care leads to low birth weights, and children with low birth weights experience increased rates of neurologic and mental defects which may result in conditions that ultimately will have to be funded by society.

Current privation mandates future satiation. Recent studies hint at the magnitude of the future cost. One explored the consumption of services by

	1985	1995
Total Health Resources	$1.00	$1.00
Physician Share	.25*	.20*
Indigent Care	.15	.20
Other	.60	.60

Physician Loss (1985-1995) = $0.05 ÷ Physician Share (1985) = $0.25

5¢/25¢ = 20% Loss By Doctors

Medicaid patients immediately after enrolling them into an HMO. First-year usage of medical resources was 550% higher for the Medicaid than for the non-Medicaid enrollees! Another study examined the effects on hypertensive patients of California's Medi-Cal cutbacks in 1982. One year following the cutbacks, the average diastolic blood pressure of disenfranchised hypertensives increased by 10 mm HG — an increment known to significantly increase the incidence of stroke, heart disease and renal failure. The final bill to society for these complications remains speculative but obviously will be enormous.

Physicians cannot afford to ignore the medical requirements of one quarter of our population. The totality of medical reserves is finite; if the flow of resources drained by the poor accelerates, the remaining resources available for physician fees and other services must shrink.

Let us examine the following scenario: Assume that the total health resource pool is fixed in 1985 dollars and that all other demands on health care, excluding the poor, are stable. Assume also that failure today to provide preventive health care for the poor increases their total proportion of the health budget by an additional 5% in 1995. If the total amount of resources is constant, where is the extra 5% of cost to be derived? Probably from physician fees. Physician fees currently consume about 25% of the total health budget. If we surrender 5% of the total health care dollar, our actual loss in real wages is 20%. Economic preservation, if nothing else, should motivate each physician to participate in the resolution of the health care crisis for the indigent.

Politically, it is imperative for physicians to wrestle with and prevail over the problems of indigent care. Our leadership role in health care policy has steadily eroded since Medicaid and Medicare were enacted in 1965. Government now realizes that it can no longer efficiently and economically provide medical care for such a large share of the population. Government is temporarily weary of the battle and, in a gesture of exhaustion, has retreated from its obligations to health care. If organized medicine can opportunistically use government's current policy of confusion and retreat to imaginatively and forcefully provide solutions to indigent care problems, we may be able to recapture our primacy over medicine. Conversely, if we abandon care of the medically indigent, doctors as a group will sacrifice the remaining respect and prestige they enjoy within society. Such a loss of esteem will deprive the profession of the small residual political leverage it savors. Thus, ethical, economic and political concerns mandate that we embrace as our own the problem of the medically indigent.

Option II: seeking increased government funding: • This option entails lobbying government on all levels for greater financial support for medical care and should be rejected immediately. It is untimely because federal and state governments are interested in truncating, not enlarging, their budgetary social commitment. It is hypocritical because organized medicine has traditionally resisted governmental meddling in day-to-day patient care. It is threatening to the physician's freedom because of increased government regulation.

Option III: continued stratifying of health care delivery • This option is perhaps more reasonable. Historically the majority of indigent care has always been assumed by a limited number of institutions. In cities the house staff and faculty of inner city volunteer teaching hospitals, and the staffs of other public hospitals, have provided 75-80% of indigent care. County hospitals and health clinics have provided indigent care in rural and suburban regions. County hospitals and health clinics, however, commonly provide only acute care and preventive medicine since frequently they are not equipped with the technology and house staff of the teaching institutions and do not provide the same degree of sophisticated care such as kidney dialysis, transplant programs and cardiac surgery.

DRGs and cuts in Medicaid have depleted the financial reservoirs of most indigent care hospitals. These institutions are surviving by deficit funding and teetering on bankruptcy. Their financial plight is not due to inefficiency or poor management; it is due to lack of revenue. Some hospitals pay for indigent care by shifting the expense to private patients. As indigent care institutions fill their beds with the poor, their private patient census has declined. Further cost shifting to private-pay patients is no longer possible. Recently bloated demands on their services have been perpetrated by the practice of "dumping" economically high risk, uninsured patients from for-profit hospitals to public hospitals. Hospitals com-

mitted to serving the poor cannot continue to absorb more unfunded care, even though the indigent ranks are burgeoning. Private medicine must divert some of the pressure from this indigent care system or it may collapse. If it fails, the government will be forced to substitute the wreckage with a hastily-built system which will be far less desirable than what we now have.

How can we optimize physician participation? •

(a) Streamline Overhead. A low overhead system that minimizes time involvement can be structured. It might be advantageous for doctors to work for the indigent during hours they presently do not work and at places other than in their own offices. Indigent clinics which employ volunteer workers can provide the most cost-effective means of seeing such patients. The Florida Arthritis Foundation has done this for years. The Foundation pays no money for the care of indigents but recruits volunteers to work in, schedule and coordinate their clinics. It also trains volunteers not only to educate patients about their disease but to teach them how to exercise and adapt their activities of daily living. This use of a volunteer workforce limits the expense of providing services. For instance, personnel costs for most private rheumatologists vary from $30-$60/hour. A 15-minute office visit with an indigent patient, therefore, consumes $7.50-$15 of personnel overhead alone. In a clinic manned wholly by a volunteer workforce, this overhead expense is reduced to zero. We should extend this type of volunteer participation in indigent care to other community service organizations. Time donated by lay people can diminish the financial burden imposed on the physicians who accept indigent care responsibility and hopefully would encourage more physicians to participate in such a system if the burden of care was disseminated fairly among professionals.

(b) Increase Productivity With Paramedics Physicians can expand their roles by overseeing clinics in which physician's assistants and nurse practitioners operate. These paramedical individuals can examine and educate patients, record data and dictate the doctor's decisions regarding diagnosis and treatment for transciption into the chart. Such personnel can increase physician productivity and reduce physician time in providing a service, particularly in the areas of pediatrics, family practice, internal medicine and prenatal care.

(c) Ration Services. Perhaps some types of care for the poor will have to be rationed. If the system has only "X" amount of dollars for indigent care, does it make sense to consume as many dollars to replace a hip joint in a 75-year-old arthritic as it takes to treat 10 hypertensives for one year? I think not, particularly when lack of hypertension treatment may generate a future demand on the dollar reserves of the system that can be 10 times more costly than the original hip surgery. On the other hand, joint arthroplasty would be indicated for an individual with a high likelihood of returning to work and escaping his indigent status.

We should develop criteria for the use of expensive, high technology practices such as intensive care for the terminally ill. The health economist, Eli Ginzberg, recently commented that, "Medical care is not that expensive; it is dying care that must be restrained." Economic as well as scientific and ethical considerations will have to be factored into our judgment algorithms.

Care also may have to be rationed to the non-compliant and irresponsible. The reasons for non-compliance, of course, should be weighed individually but patients must be impressed with their responsibilities to the system. If they waste scarce resources, they effectively deny services to other worthy, needy individuals.

The concepts of rationing and stratifying health care may scarify the ethical instincts of many physicians. The realities, however, are that all societal needs including housing, education and food are rationed or stratified by economic considerations. Financial criteria assign people to the level of care they will receive. Planned, rational entry into the health care system based upon economics is not ideal but certainly surpasses the current health care system which is haphazard, unstandardized and accelerating toward annihilation. Total access has been curtailed by government with no thought given to the long-term costs of such cutback in funds. It seems more logical to exclude or limit certain high cost types of care and procedures where long-term economic benefits are questionable but not reduce all care, including that which is economically sensible.

Option IV: devising alternate approaches • The fourth option is to formulate multiple plans tailored to an individual community. The scope and resources for indigent care in Miami differ from those in Daytona Beach or Pensacola. A national or statewide system cannot mesh with such distinctive, parochial requirements. County medical societies should initiate the design of more comprehensive local programs and enlist the cooperation and input of the health department, all hospitals (including the proprietary, public and volunteer hospitals) and all

volunteer and other health care provider groups. The size of the local indigent population needs to be assessed and their health needs profiled. Both current and future total community resources derived from insurance, Medicaid, taxes, philanthropy and volunteer agencies should be measured. Allocation of all resources must be prioritized according to long-term economic, medical and educational goals of the community. Perhaps different professional fee schedules will have to be constructed based upon physician cost of indigent care. For instance, the obstetrician who delivers an indigent mother may be entitled to a higher fee because of his higher malpractice risk than a surgeon who performs a procedure requiring similar skill but less malpractice risk. After its design, public input could be invited and modifications inserted. All physicians should be encouraged to participate in such community-wide progams.

After implementation of a local system, continuous documentation and periodic analysis of its results should be gathered and presented so that comparisons of results among different locales can be made and flexibility, adaptability and upgrading can be secured. The system design will be laborious and require enormous volunteer work on the part of physicians and other health care workers. These concepts will discourage many; however, providing our own system can avoid further government seizure of our professional privileges and freedom. I see no other choice.

Florida has recently provided the impetus for such programs. As of July 1, funds for indigent care were granted to local county health departments for distribution. Perhaps we can use this state initiative as a nidus upon which to crystallize a more comprehensive system.

The gauntlet of care for America's displaced indigents has been cast at the feet of organized medicine. If we accept the challenge and provide the imagination, energy and organizational skills necessary to partially or wholly resolve the problem, society will perhaps allow us to re-establish our credentials as appropriate caretakers of the public's medical welfare and restore to us our lost leadership in American medicine. We in Florida have an opportunity to lead the nation in responding to these issues. I would hope that the FMA will harness the forces necessary to do so.

References

1. Blendon, R.J.; Rogers, D.E.: Cutting Medical Care Costs: Primum Non Nocere. JAMA 250:1880-1885, 1983.
2. Feder, J.; Hadley, J., and Mullner, R.: Poor People and Poor Hospitals: Implications for Public Policy. Journal of Health Politics, Policy and Law, Vol. 9, No. 2, pp. 237-250, Summer 1984. Dept. of Helath Administration, Duke University.
3. Ginzberg, E.: Prospects in Medical Care: Physicians, Patients, Practice. Mount Sinai J of Med 51(3):258-261, June 1984.
4. Hadley, J.: More Medical Care, Better Health? Washington, D.C.: Urban Institute Press, 1982.
5. Health Market Survey 2(10):1-8, May 30, 1985.
6. Horn, S.D.; Bulkley, G.; Sharkey, P.D., et. al.: Interhospital Differences in Severity of Illness. Problems for Prospective Payment Based on Diagnosis-Related Groups (DRGs). New Engl. J. Med. 313(1):20-24, July 4, 1985.
7. Horn, S.D.; Sharkey, P.D., and Bertram, D.A.: Measuring Severity of Illness: Homogeneous Case Mix Groups. Medical Care XXI(1):14-30, January 1983.
8. Mulstein, S.: The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options. Inquiry 21:214-229, Fall 1984. Blue Cross and Blue Shield Assoc.
9. Rogers, D.: The President's Statement. In the Robert Wood Johnson Foundation Annual Report 1982. Princeton, N.J.: Robert Wood Johnson Foundation.
10. Sager, A.: Why Urban Voluntary Hospitals Close. Health Services Research 18(3):451-475, Fall 1983

Jacques R. Caldwell, M.D.
Daytona Beach

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Your Avis AWD Number:
A/A 616900

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

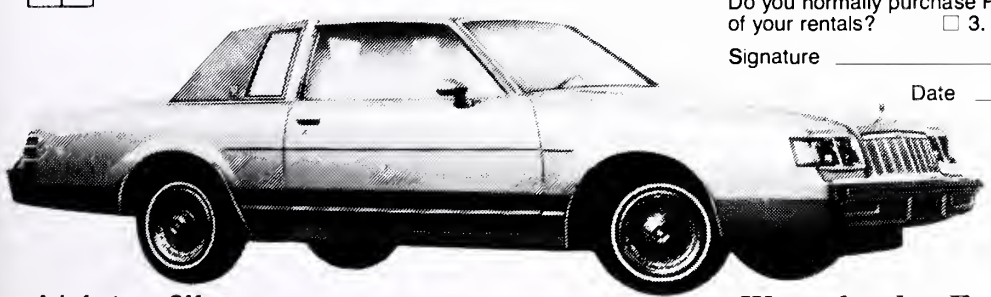
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ; LaGuardia Airport, NY; JFK Airport, NY and all Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

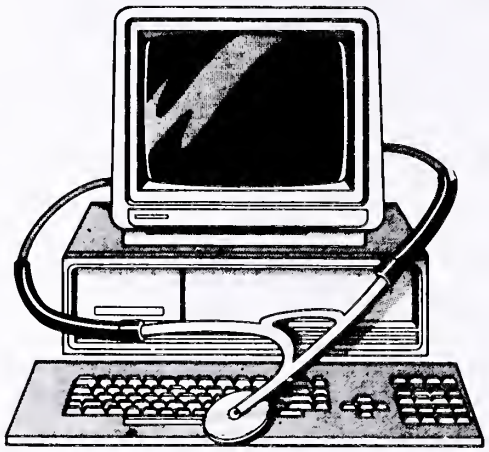
©1985 Avis Rent A Car System, Inc., Avis®

3/85 Printed in U.S.A.

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 703
- ☐ DEAN'S MESSAGE, 704
- ☐ ENCORES! 704
- ☐ SCAM OF THE MONTH, 710

NOTES & NEWS

Dr. Prather appointed State Epidemiologist

Luis M. Perez, M.D., President of the FMA, recently wrote David H. Pingree, Secretary of the Department of Health and Rehabilitative Services (HRS), endorsing his appointment of E. Charlton Prather, M.D., M.P.H., as State Epidemiologist, to become effective October 14, 1985. Dr. Prather who is currently serving as the Health Program Supervisor for District II of HRS, is a nationally recognized expert on epidemiology and communicable disease control. He was originally named State Epidemiologist by the old State Board of Health in 1960, a position Dr. Prather held until July of 1974. He will reassume this position in October of 1985.



Dr. Prather

The establishment of the position of State Epidemiologist was approved by the Legislature in the 1985 Appropriations Act. Governor Graham included the position in his budgetary request to the Legislature, which was a positive response to a resolution by the House of Delegates approved at the 1985 Annual Meeting resolving that the position of State Epidemiologist be re-established.

Dr. Prather was Florida's State Health Officer as Director of the Division of Health and, after the reorganization of HRS, Staff Director of the Health Program Office from 1975 to 1979. He received his Doctor of Medicine degree from the Bowman Gray Medical School, Wake Forest, and his Master of Public Health degree in Epidemiology from the University of North Carolina at Chapel Hill.

As a member of the Florida Medical Association since 1959, Dr. Prather has fully participated in the activities of the FMA and its component specialty and county medical societies.

He has served on the FMA Council on Specialty Medicine continously since 1965. He is a Past President of the Clay County Medical Society and is currently a member of the Capital Medical Society. Dr. Prather was also the President of the Florida Society of Preventive Medicine.

Born in Jasper, Hamilton County, Florida, Dr. Prather is truly a Floridian. Dr. Prather has well served the public health needs of Florida's entire population. He continues to be an invaluable member of the medical profession and brings to the position of State Epidemiologist the full support of the FMA.

Dr. Feinstein steps down as editor of Miami Medicine

Richard J. Feinstein, M.D., has resigned as Editor of *Miami Medicine* after five highly successful years. During his tenure, he contributed 54 editorials and won several awards in *The Journal of the Florida Medical Association* Annual County Medical Bulletin Awards Contest. He has recently been named a Contributing Editor of *The Journal of the Florida Medical Association.*

Dr. Feinstein serves as Associate Clinical Professor of the Department of Dermatology at the University of Miami School of Medicine. A graduate of the State University of New York College of Medicine, he did his internship at Georgetown University Medical Division, District of Columbia General Hospital. He did his residency in dermatology at the University of Miami School of Medicine and Jackson Memorial Hospital.

Dr. Feinstein is actively involved in many professional organizations such as the Florida Dermatology Society, American Academy of Dermatology, and the Florida State Board of Medical Examiners.

In addition to serving as Editor of *Miami Medicine,* he currently is the only physician member of the Board of Contributors on *The Miami Herald* newspaper and he is the Editor for the Florida State Board of Medical Examiners' Newsletter.

Workshop on Marketing Strategies for Private Practice

A workshop on "Marketing Strategies for Private Practice" will be held on Saturday, September 7, in Kissimmee, Florida. Sponsored by The Florida State Society of Medical Assistants, it will be conducted by

Barbara Gore, Program Director of the Department of Practice Management of the American Medical Association.

The workshop will focus on specific, practical techniques that can be used to develop a coordinated marketing plan for a physician's office, enhance patient satisfaction, and maximize the efficiency of existing office procedures. The program will include several topics of discussion, including the "Doctor Surplus", the marketing process and marketing research, maximizing patient satisfaction, pricing physician services and increasing practice visibility. Each participant receives a copy of "Marketing Strategies for Private Practice"[SM] workbook, which conforms to the format of the workshop.

Application has been made for Continuing Medical Education credits for physicians and medical students. The deadline for registration is August 23, and prompt registration is urged as the number of participants in limited. The workshop, to be held at the Hilton Inn Gateway in Kissimmee, begins at 9:00 a.m. and ends at 5:00 p.m., with registration from 8:30 to 9:00 a.m. Hotel reservations are to be made directly with the Hilton Inn Gateway at (305) 396-4400.

DEAN'S MESSAGE

Preventive Medicine

It has not been so terribly long since each practicing physician was expected to be as adept a counselor for both the community and the individual with regard to public health as he was a practitioner of illness care. Public health practice as it pertains to the community has now evolved into an independent specialty that meets even the strictest definition of specialty practice. Graduate training in Public Health is through a residency program with several tracks including not only public health administration, but also preventive medicine, aerospace medicine and occupational health. There are well established certifying boards. Public health practice is at least as demanding as any of the other medical specialties.

What public health as currently practiced cannot do, largely for mechanical reasons since it is community oriented, is offer individual consultative advice patient by patient on matters of personal preventive medicine and health care.

Preventive health care is no less essential than illness care; however, the public and our profession alike have been slow to acknowledge that indeed it has real value. Prospective preventive medicine has always been taught to be an integral component of illness care. An appreciation of the value, not just the common sense value but the dollars and cents value, of preventive medicine when offered before the fact rather than after the illness has been a quiet revolution in health care. If preventive medicine is successful, the result is continued good health, which most of us hope to enjoy in any case, and as a product it is difficult to both document or sell.

There is a world of nonphysicians selling good health maintenance advice and legions of hucksters offering advice which is at best questionable and occasionally harmful to more than one's pocketbook. The line between good health habits and prescriptive health maintenance often is subtle. There are many patients for whom the simplest health advice should be tempered by a comprehensive knowledge of their medical history. In the foreseeable future, preventive medicine will remain an inseparable component of each physician's practice of medicine and an essential component of the undergraduate, graduate and postgraduate medical curricula.

William A. Sodeman Jr., M.D.
Deputy Dean for Academic Affairs
University of South Florida
College of Medicine

ENCORES!

Renaissance of medical humanism

The Council of Medical Education of the American Medical Association has noted the need to reemphasize the desirability for potential physicians to obtain a cultural education in order for them to be humanistic and sensitive to patients from varying backgrounds.

That the humanities provide important preparation for medical education is a dogma little disputed by medical educators. The humanities are expected not to intrude into classroom discussion or take precious time from technical studies in medical schools. Medical educators expect their students to bring a "liberal" education with them.

Patients and physicians are in an essentially personal interaction which depends upon a proper balance between scientific and humanistic thinking. Yet humanistic skills are neglected in medical education today. The humanities have suffered dilution in the pre-medical years since the nineteen forties.

Patients and public agencies are becoming more vocal about what they describe as an insensitivity to values in medical affairs. They use words like "dehumanization," "humiliation," insensitivity," and other derogative adjectives to describe the experiences of patients in America.

Humanism can best be defined as the philosophy which recognizes the value or dignity of man. It makes man the measure of all things. The term "humanism" is derived from "humanitas" which at the time of Cicero meant the education of man by the liberal arts, instruments which disciplined man properly to differentiate him from other animals.

America needs to train humanistic physicians. We must not minimize or supress humanism in medical education. Reorientation toward the history and culture of antiquity can effect a reorientation towards a more human future for the medical profession.

The cultured physician of the past possessed an ideal order of knowledge and being. The whole of reality, social, political, economic and intellectual was in principle, a hierarchical system of clearly defined minute subordination and superordination.

We must not overlook the old curriculum based on grammar, rhetoric, history and moral philosophy. The dignity of man in the technological society requires the literary and scholarly knowledge of the classical past. A study of the classical past in a comprehensive sense of the word would develop the kind of sensitive intuition and subtle powers of judgement that will permit physicians to advise and to act wisely amid the complexities of the ever increasing dehumanized technological society.

A more humanistic physician would be able to handle better the mass of complexities, ambiguities and imponderables he meets in the practice of medicine. Many of today's physicians are unprepared by their medical education to examine and deal with the questions of sensitivity of patients' values in our technological society.

In the Western World we talk about the educated man and frequently identify him with the cultured man. But an educated man like a physician is not necessarily a cultured man. The cultured physician is not the merely knowledgeable person, but the person who is knowledgeable and uses his knowledge humanely.

The cultured physician is an artist, an artist in humanity. His art consists, in part, in the ability and the skill with which he wields the tools of knowledge and experience. The cultured physician believes that the only philosophically tenable position even for a pessimist in these days is optimism. He knows that compassionate understanding and sympathy is the approach of the humane, while blame and censoriousness is the approach of the insufficiently humane.

Physicians are beset on all sides by a host of problems that are on the verge of destroying free medicine in America. The hopes and fears which pervade the modern medical society rest on the moral fiber of the physician, and on the wisdom and responsibility of those who promote the course of its development.

Doctors are at a crossroads: one road to an almost dehumanized medical society run by the government with the physician as a helpless cog in a machine; the other to a renaissance of humanism to a free medical society dedicated to the service of man's well being.

Edward Pedrero Jr., M.D.
Tampa

Reprinted with permission from *Hillsborough County Medical Association Bulletin*, May 1985, Vol. 31, No. 1.

Do we have any choices?

This article began several months ago, on the floors of Fish Memorial Hospital, as I was lamenting no, complaining about one of the more recent decisions forced upon me by the hospital reimbursement policies of the PRO. A patient undergoing a pacemaker insertion, and subsequently, a hernia repair, required two separate hospitalizations, so as not to incur a DRG loss for the hospital. In addition, the patient had to endure an additional ten days of discomfort, while awaiting his hernia repair. The logical and more cost effective approach would have been to repair the hernia while he was recovering from the pacemaker insertion.

The absurdity of all this was exasperating. I thought, "Can't something be done about this?" I have written a letter to HCFA, in hopes of enlightening them.

The whole episode, however, exemplifies the most crucial problem facing physicians today. We are losing control over the decisions regarding patient care. Extending this even further, we are losing control over many decisions affecting the medical profession.

Under the banner of "Quality health care and cost containment," great changes are sweeping the health care industry. Some of these changes are overdue, but others threaten to complicate and even hinder the delivery of quality care.

Medicine as we know it today is under siege. Government regulations and DRGs have caused economic concern. The malpractice insurance crisis looms constantly over our heads, forcing us to practice defensive, and at times, cost-ineffective medicine. HMOs, PPOs, Networks, and the like threaten to swallow us all, endangering the existence of the private practitioner.

Superimposed upon all this is a much more intelligent, informed and demanding consumer public than ever before. Through rhetoric, political action and legislation, the bureaucrats have converted physicians into a mere parcel of the health care product. Physicians are not accustomed to being viewed in such terms. After all, we are professionals. We serve our patients, not customers. We are engaged in the practice of medicine, not business. Ethical and sociopolitical considerations notwithstanding, the major forces of change relate to economics.

Any observer outside of the medical profession might easily conclude that organized medicine is self-serving, protecting doctors' pocketbooks. Obviously, that is a gross oversimplification. Of course, we are concerned about our financial futures. So is every other segment of our economic society: laborers to lawyers, accountants to airline pilots, and so on. We need not feel guilty about that. In the context of our economic society, we work hard, and should enjoy the fruits of our labors, both in the personal satisfaction of helping our patients, as well as enjoying a high standard of living.

It would be grossly unfair to state that our only concerns are our personal fortunes. Above all, we are the patients' advocates. Physicians, not administrators or bureaucrats, still know what is best for patients. The ultimate responsibility for patient care decisions must remain in the hands of physicians.

To summarize: the government, lawyers, corporations and the public expect the very best health care at the cheapest prices and demand that we bear the full burden of responsibility. In product lingo — they want the quality of an expensive automobile, complete with all guarantees, for the price of an economy car.

The changes occurring in health care have been inevitable. Certainly, the medical professional has resisted changes, not always constructively. Our political efforts in that regard have often been perceived by the public as being self-serving. Perhaps our obstinacy and lack of political savvy have militated against us. Perhaps we simply have not done a good enough job at public relations.

The purpose of this article is not to find fault with the past, but to engender positive constructive action in the future, starting now. I do not intend to dispense a solution for the problems facing us. In broad conceptual terms, however, I would like to offer some thoughts, starting with the most basic of questions asked us: "Why do you want to be a doctor?" I dare say the answers would include the concepts of helping our fellow man, engaging in an intellectually satisfying endeavor, enjoying economic security, and exercising some control over our destiny. Placing these goals in the context of our present problems, the key word is control, a euphemism for power. Who will have the power? Do we have a choice?

It goes without saying that the patient is the "star" in this show. It is the patient who must be the recipient of our greatest ideals and skills. Unfortunately, the government, hospital corporations, hospitals, insurance companies and yes, even physicians, (though we have been the last to realize it) are locked in a power struggle for control! All this thanks to the ugly word — Economics. What most do not understand is the patient's primacy in the grand scheme of things. He is caught in the middle.

From the standpoint of physicians, we are experiencing less control over therapeutic decision making. Our economic security is threatened and our ability to control our destiny is uncertain. This is just cause for concern.

What can be done? First of all, we must come to grips with reality. The service we render is a product. Health care delivery is big business, and we are part of it, like it or not. If we don't run the business properly, someone else will. I would also like to dispel the view that there is no problem. Many say, "So what! We'll just live with it, adjust, make do, it won't be so bad." Observations of other countries' systems bespeak the contrary.

Many physicians work for large groups or corporations and are perfectly content. I do not condemn that. Large numbers of graduates from medical schools and training programs have not experienced the practice of medicine as we know it. They may want no part of economics or politics. These groups may not experience a problem now, but as economic forces come to bear on all of us in the future, they may ask, "where did we lose control?" Some would say it is too late, nothing can be done. Perhaps so, no one knows. It is certain that "nothing ventured, nothing gained." History is replete with examples of societies failing to see the handwriting on the wall, only to crumble. A defeatist attitude, burying our heads in the sand, hoping everything will be acceptable, will eventuate in defeat for us and our patients. Some would advise the formation of a physician's union, a physician-owned insurance company or other such entities. I am certainly not in control

of the data required to advise any one specific course.

Common sense, however, demands one overwhelming alternative; that is action — not just knee-jerk reaction. We can be part of the changes. We can mold them. We can look inside ourselves, look at the needs of our fellow-man, and promote policies that show we are receptive to peoples' needs. Organized medicine can be the vanguard of imaginative legislation. We will have to make compromises to maintain our credibility. Nothing stays the same forever.

All of this takes work. It means attending meetings, writing letters, becoming politically informed and active. It means hard work in salesmanship and public relations, starting with our own offices, cultivating rapport with our patients and the community at large. We must be able to prove to the public that the concerns of the patient and concerns of the physician are not mutually exclusive.

We cannot afford to isolate ourselves within our individual practices. Of course, differences of opinion exist between members of individual hospital staffs, so even greater differences might be expected between the various areas within a county and certainly between the various areas within a county and certainly between county medical societies. Furthermore, it is understandable that our differences are not just petty. We must work together, however, to attack the issues and problems which transcend our individual preferences. We must define the goals which are common to us all and work to achieve them.

I have not said anything new. All of you know what is happening. I am making a plea, if you will, for unity and action. The trite phrase, though often used, is no less applicable — "United we stand, divided we fall."

Avrohm Faber, M.D.
New Smyrna Beach

Reprinted with permission from *The Stethoscope*, Summer Issue, 1985.

What can doctors do when a colleague is incompetent?

There's an isolation notice on the hospital room door. Inside, the silence is violated by the ragged, agonal breathing of a 55-year-old man I've known for a year. The staff doctors tell me he's sunk into a coma, ravaged by an infected brain, paralyzed on one side and unable to talk. He has AIDS.

I stand at his bedside. His head is skewed to one side, his breaths are rapid and rasping and his face is pale and soaked with sweat. Expecting no response, I say his name. But he opens his eyes and looks at me, an intelligent look. One brow goes up.

The look tears through me like a knife. A few minutes later, I creep out of the room, feeling like the worst doctor ever created. It's not that we are not giving him every appropriate medicine. It's not even knowing that we cannot cure AIDS. But when I see intelligent awareness in the midst of the pain of that ravaged body, I cannot bear not being able to relieve it.

I want to be a "good" doctor, and "good" doctors relieve suffering. I want desperately to be able to give him enough narcotics to stop his suffering — whether that pain is physical or simply the agony of not knowing whether you will be able to manage another breath.

Of course, that much narcotics might also end his life, and "good" doctors are not supposed to kill.

Furthermore, I do not know that he would wish it of me — and he cannot say.

His family and I have decided that we will not interfere when he stops breathing, but now, all I can do is shift his pillow, touch his shoulder, check the medications, wonder how long this can go on — and feel like a very bad doctor.

People in and out of medicine have very definite ideas about what makes a bad doctor. Some, incompetent because of alcohol or drug abuse, injure or kill their patients. Others are sufficiently unscrupulous to deliberately perform faulty, dangerous procedures — like incomplete abortions — so they will have to be repeated at additional cost.

It has been estimated that between 5 and 10 percent of the nearly half-million doctors practicing in the United States are incompetent or unscrupulous.

We read about some of these people. Their outrages make headlines — like the specialist who was videotaped sedating a patient and preparing to rape her; or a psychiatrist who settled out of court after being accused of having sexual relations with his patients; or a so-called cancer doctor who sold "cures" to the terminally ill, taking the last of their money before they lost their lives.

A bad doctor may be mentally, professionally or physically incompetent, or suffering from ignorance or stupidity, according to Dr. Robert Derbyshire, former president of the Federation of State Medical Boards, in a report compiled by the Senate Special Committee on Aging last year. That first group — including impaired physicians whose safe, skillful practice of medicine is hampered by drunkenness, drug abuse, mental illness, disease or senility — is the largest, he says.

Unscrupulous doctors — the worst of the lot — are those who realize they are impaired but continue to do what they know they cannot do safely, or those who choose to practice bad medicine — like trading narcotics for sexual favors — for pleasure or profit.

Most people are not able to judge a physician's professional competence, so perhaps it's natural that they put greater weight on warmth, reassurance, effective communication and caring. From a patient's point of view, a doctor who makes you feel good is good.

But other doctors, in a better position to evaluate technical competence, look out for unreliability, sloppy practice, poor judgment, outmoded training or poor technique.

We doctors like to think that physicians no longer have to protect their own that way — that the conspiracy of silence is long past. But it's hard to tell.

"Either we're doing a fantastic job of choosing who will enter our medical schools, or we just aren't catching the bad one who make it through," wryly comments a physician and administrator who serves on the Education Evaluation Committee at George Washington University, the committee responsible for making determinations about the competence or professional comportment of medical students who get into trouble.

"You know, I greatly admire airline pilots," he adds. "They police themselves very seriously. They're required to be recertified for competence every six months. I wonder how many of us doctors, myself included, would be able to pass such exams."

Personally, I feel like a bad doctor more often than I'd like. Sometimes I fell inadequate; others, impotent. As this man lies dying, I'm plagued by both.

Colleagues, pained by difficult cases, have expressed the same feeling. Moreover, I think most good doctors actually do practice bad medicine occasionally. It is almost impossible to be appropriate all the time.

That's why, in trying to judge medical care, we have accepted the notion of "standard of care."

No one can be expected to solve every problem, get every diagnosis right. If a doctor offers at least the level of care in any situation offered by most doctors in the medical community, he's not considered to blame if the outcome is not good.

The principle sounds simple, but it isn't always. Sometimes there are are many appropriate approaches to a problem and none of them gives the right answer. Other times, the approach can be all wrong, the thinking off — but the problem gets solved anyway.

During my residency training, a young woman was admitted to my service by a private physician, with the diagnosis "fever of unknown origin." That is a technical diagnosis applied appropriately only under certain circumstances — not hers.

Four days earlier, this private physician had seen her in the office and she'd had a fever. When she called saying her temperature was still high, he simply admitted her to the hospital without reevaluating her first.

Young doctors in training are notoriously self-righteous about such cases; they think the outside physician hasn't done his homework. In this instance, I spoke for a few minutes with the woman, put a hand on her belly, swallowed my irritation and called her doctor to get the name of the surgeon he'd prefer. She had acute appendicitis.

"He got her into the hospital, where she needed to be, didn't he? And on time," another resident pointed out. "He must be doing something right."

Before my training ended, we came to regard that as a joke: There were two or three doctors whom we considered bizarrely reliable in that a person they admitted to our hospital always needed to be in there — but never for the reason the doctor considered to be the diagnosis.

Some of those doctors probably managed to keep out of trouble because they recognized their own limitations, I've since decided. When they didn't know what to do, they hospitalized someone or sent him to an expert.

Their training may not have been up to date, but they did know when someone was genuinely sick, and they knew how to signal for help when they required it.

The more I run into diagnostic puzzles myself, the less of that old self-righteousness I find I retain. It's still easy for me to censure bad doctors, but less simple to assume that inadequate medicine always means a bad doctor — sometimes its a good doctor who doesn't have all the answers.

Of course there are those utterly horrifying cases of doctors who end up killing their patients because of repeated ineptnes or venality. We wonder how these people ever made it through training and into practice without getting caught.

We read that their malfeasance actually took place over more than 10 years, or that they were sued for malpractice many times, and ask, astonished, "Didn't anyone complain? Why wasn't this person caught?"

For some, problems may have been evident in medical school. Every year, a few people get into trouble at George Washington because of poor academic performance or inappropriate professional behavior — cheating, shoplifting or taking drugs, for example.

Complaints against students that carry a threat of dismissal trigger investigations by the Education

Evaluation Committee. But the Committee needs concrete, adequate evidence of bad performance.

Not infrequently, lawsuits are brought against the medical school by those students who have been dismissed. They will go to all ends to gain reentry, and the legal actions are time-consuming and very expensive for the medical school.

"But we take our obligation to turn out competent, honest doctors extremely seriously," comments one of the medical school administrators. "We don't hesitate to act if we think the public would be threatened by inappropriate or unprofessional behavior on the part of one of our potential doctors."

A person whose drug abuse actually led her to demand a urine specimen from a patient to pass of as her own was dismissed several years ago. So was a person who falsified credentials to state she'd graduated from a professional school — she had actually dropped out. Others simply flunk out.

But even dismissal from medical school may fail to short-circuit the careers of people with problems. Almost all the medical students who have been dismissed in recent years at George Washington have ended up in off-shore medical schools, which can provide a path back into the American medical system. One we recently learned about quite by accident.

He was about to be fired from a residency program elsewhere, which he had entered without ever revealing that he'd been dropped from an American medical school. Persistent incompetence was what got him in trouble there — yet the residency program only discovered accidentally that he'd ever had problems before.

"You know, if we paid more attention to the reasons for program-hopping, or for doctors moving from state to state, we might do a more effective job of keeping these people out of medicine," one committee member commented. "But no matter what these people do, someone seems to write letter for them, recommendations that get them another spot."

In fact, according to Derbyshire, sometimes an agreement with an incompetent doctor to get him out of a hospital or a state includes concealment of malfeasance or providing good recommendations.

One reason so few doctors are drummed out of the system is that others are often reluctant to come forward and testify for fear of a retaliatory slander suit.

A doctor who did file complaints in a case involving illegal abortions and serious injury to some of the victims says ruefully, "I did it because I think it was right and I was the appropriate person. But I'll tell you, I got threatening phone calls every night until this man finally surrendered his license — and the FBI told me if anyone suspicious came too close to my house, I should take out my rifle and shoot."

This doctor became involved when information was brought to him about a woman who'd had an abortion that appeared to be botched in a number of ways. First, the abortion was attempted much too late in the pregnancy — the fetus might have lived.

Moreover, the membranes protecting it had been ruptured, creating a massive infection that proved fatal to the fetus. He reported the case to the police, but the doctor involved was not prosecuted at the time.

Months later, another woman, with a pelvic abscess and a disfigured vagina after a botched abortion by the same doctor, came to GW seriously ill. On top of everything else, this doctor had given her the wrong antibiotics.

This time, the George Washington staff doctor went to the head of the District of Columbia Healing Arts Commission — the board that licenses District doctors and hears complaints against them. A year later, the physician at fault finally surrendered his license.

Over the years, the Healing Arts Commission has been plagued by too little money — from 1977 through 1983 there were just 11 such cases. But this year, with better funding from the city government, and the staff attorney they have desperately needed, the commission has already held six hearings in the last seven months; six more are scheduled and eight others are planned.

Even with the increased hearings this year, however, the District barely meets the 1981 annual average per state of about 11 actions with serious consequences — loss of license or probation. And those actions represented investigation of less than one percent of doctors assumed to be incompetent, Derbyshire says.

One commission staff person adds, "Some have begun to say that maybe a requirement of getting your license should be that a doctor be required to step forward and testify" if he sees wrongdoing.

In Arizona, where physicians are compelled to report malfactors and are legally immune from suits, the number of reports has quadrupled.

Another George Washington doctor, one who testified recently in a case concerning the competence of a heart and lung surgeon, says flatly, "If we don't police ourselves, somebody else is going to do it for us. Most of us do feel we need some kind of internal policing — but, of course, 'bounty hunters' are not highly regarded."

I think to myself that were I put in the position, I would find it difficult to do my duty and testify. I remember ruefully how difficult it is for me to make critical comments about residents and medical students I've come to know and like. I am glad I've not been tested by circumstance, I conclude.

On graduation day for the medical school, 152 new doctors solemnly repeat the words of the Hippocratic Oath — "Do no harm." I cannot help wondering: Will they all be good? Did we catch the problem people? Did anyone who shouldn't have slip through? We'll find out, but maybe not soon enough.

Carole Horn, M.D.
Washington, D.C.

Reprinted with permission from *The Washington Post National Weekly Edition*, July 15, 1985.

Remember May at the FMA

Remember May at the FMA
No longer will we have that day
The meeting is moving to September
But still the Mays we will long remember.

Driving to the Americana or Diplomat
The car getting hotter as we sat
Waiting our turn for some bellhop
As patient physicians, not ever blowing our top.

Remember the white sands, palms and sun,
Business and pleasure — all of it fun
So many meetings from which to choose
At times our minds we did lose.

Meetings of all physicians merged into one
Colleagues together ever on the run
Thanks to Mrs. Trask and the Polk County Suite
Polk County Delegates had a place to relax their feet.

May — September the month may be different
But the same ideals and goals continue unbent
Mark your calendars and be sure to go
Then your memories, like mine, will continue to grow.

Robert B. Peddy, M.D.
Lakeland

Reprinted with permission from *The Bulletin of the Polk County Medical Association*, June, 1985.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

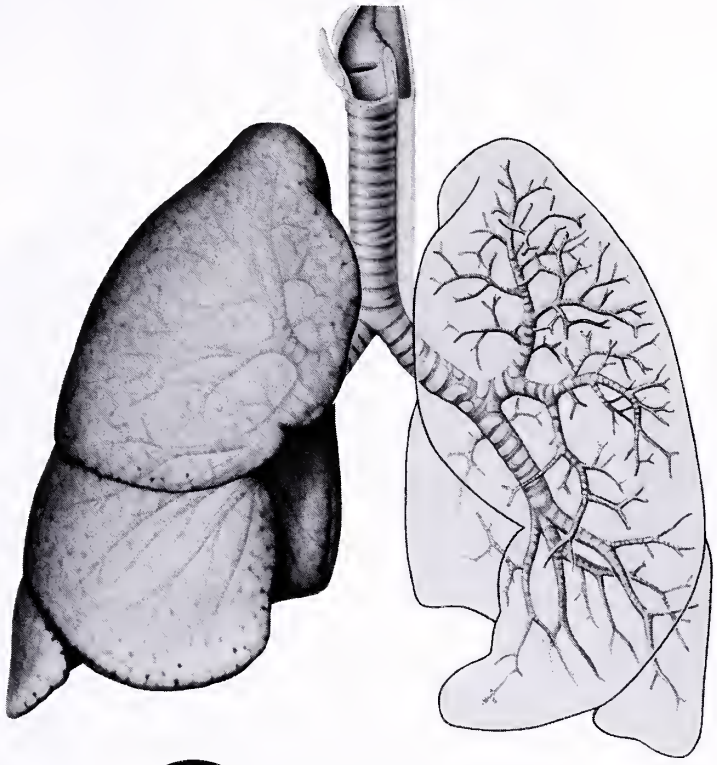
A recent Federal Court case brought this scam to light. A review of appropriate files indicates this scam has been used by a number of physicians, dentists and veterinarians.

A physician will present himself to a pharmacist and using his own prescription blank or one of the pharmacies, write a prescription for himself for a controlled drug (while this is not illegal there is some question as to whether it is ethical). Perhaps the physician will write a prescription in the name of a patient telling the pharmacist he will deliver the controlled drug to the patient; or the physician's receptionist will present a number of controlled drug prescriptions in the names of various patients to the pharmacist and take the drugs back to the office. Occasionally a patient will present a controlled drug prescription to the pharmacist and upon having it filled, return it to the doctor's office (telling the pharmacist the doctor requested it for safekeeping).

The first two situations may not be illegal but are usually indicators of possible personal addiction on the part of the doctor. The second two situations are usually absolutely indicative of either personal addiction or illicit drug sales on the part of the physician. Both of these situations are also felony violations of the controlled substances law.

Caution • Pharmacists are reminded that Controlled Drug prescriptions can only be dispensed to the person whose name appears on the prescription. Family members who present prescriptions for other members of the family might be considered acting as agents for the person named on the controlled drug prescription and would therefore be in legal possession, although this situation depends upon the circumstances. However, in just about every other case, anyone in possession of controlled drugs with another person's name on it is in felony violation of the controlled substances law.

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

430441

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

BOOK REVIEW

Book Review Editor — F. Norman Vickers, M.D.

The psyche wards, from behind a psychiatrist's door

By Russell C. Packard, M.D., 228 pages. Price $14.95. P.S. Eriksson.

Russell Packard has displaced Robert Ludlum as my favorite author. . .at least for now. In Packard's latest book, *The Psych Wards*, he portrays the many emotional ups and downs of a first year resident in psychiatry. No holds are barred as he frankly describes his own turmoil in dealing with the cross section of characters in a large naval hospital. Anyone who has seen service in a military hospital will quickly recognize the stuffed-shirts, the militant facades, the menagerie of patients one must deal with. Packard does it all. His descriptions are vivid, his insight superb. This elderly reviewer can reminisce happily at the word pictures Packard draws. Knowledgeably he points out that the learning process for the doctor comes primarily from his patients, not the boring lectures he must attend. The tremendous variations in personalities the young psychiatrist encounters are vividly described. His own reactions are frankly stated and one can suffer with him at the never ending stream of young "sickies" he must treat. The book is a series of vignettes covering more than a year in a field he finally decides is not for him. Humor is woven into his analytical efforts to treat his many patients and pathos seeps through as early confusion matures into recognized unhappiness. Any physician who harbors the mistaken idea that psychiatry is a breeze will come to a rude awakening as he reads the suffering and conflicts Packard describes so beautifully. Read it and enjoy the work of a young master.

Philip B. Phillips, M.D.
Pensacola

- Dr. Phillips is a practicing psychiatrist in Pensacola.

A to Z of women's health

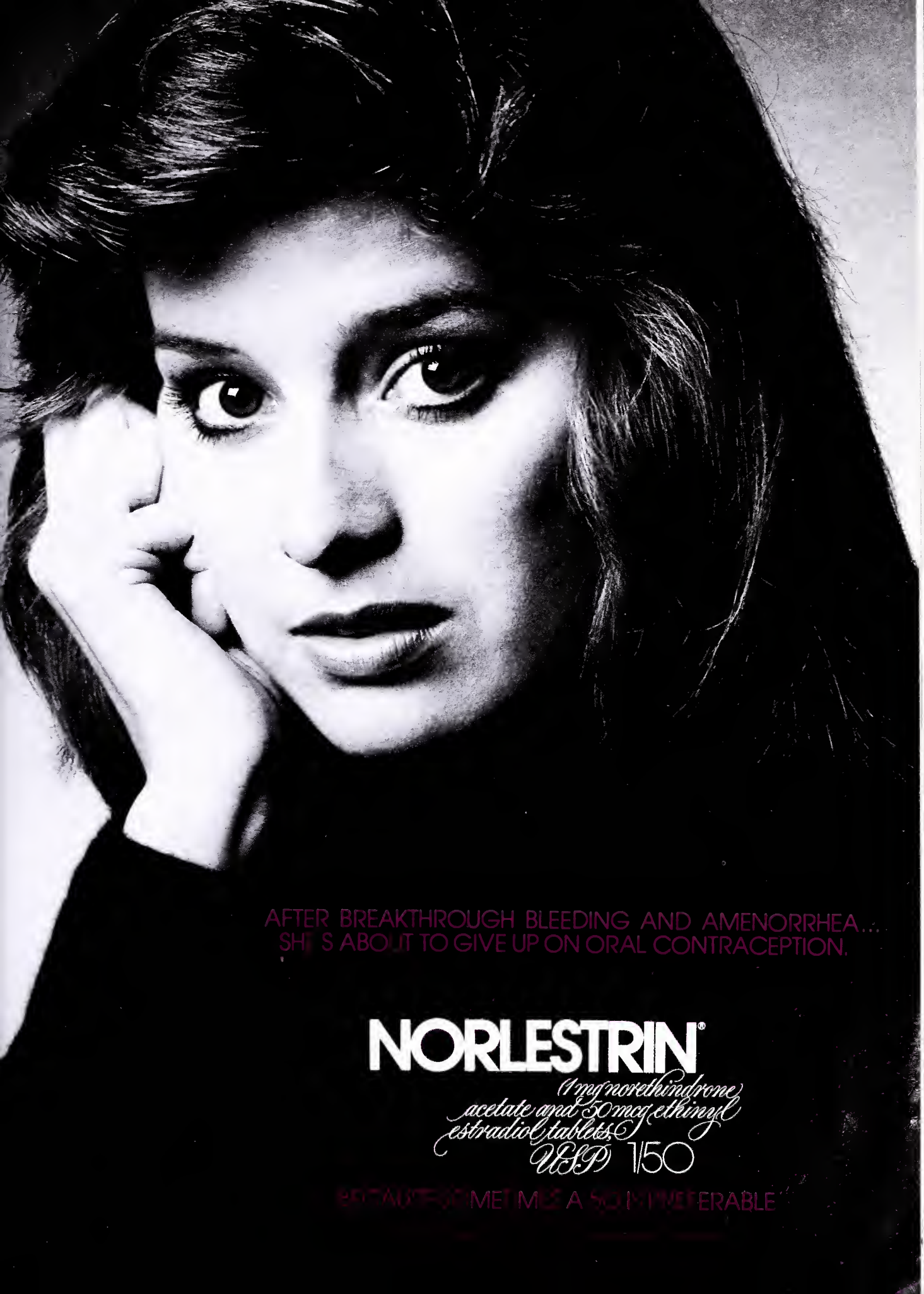
By Christine Ammer, 481 pages. Price $19.95. Facts on File.

The book *A to Z* is an extensive survey of gynecologic and obstetrical terms. It is at once too complex and too simple for a specific audience. Its detail is considerably more than would be desired by most casual readers of women's articles and yet it is beneath the level of scientific evaluation which would make it of use to trained professionals. It would seem to me that this book's best use would be in the office of those people interested in female health so that people beneath the level of R.N. might better comprehend dictation from the doctor or diagnoses given by the physician. It has a bias which is reflected in several areas; for instance, a description of mini-laparotomy as being safer and easier and less painful than laparoscopy. Basically, it

will be found to be a useable book by mid-level health care personnel. The completeness of the book is to be applauded. The narrowness of application for the proposed reader would make this a useful but certainly not a widely used book. It may have a limited appeal for those women's movements in which it has now become a desirable tool to use correct terminologies to present to the physician or other health professional. Again, this is an encyclopedic handling of a narrow area of women's terminology in disease of use to mid-health delivery personnel beneath the level of the true professional and a little too complicated for the average patient.

Doris N. Carson, M.D.
Jacksonville

● Dr. Carson has a practice in obstetrics and gynecology in Jacksonville.


AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA...
SHE'S ABOUT TO GIVE UP ON ORAL CONTRACEPTION.
NORLESTRIN®
1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP
1/50

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows

DESCRIPTION

Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE

Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS

1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision; onset of proptosis or diplopia; papilledema, or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives; however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy; Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS

1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.

2. Preexisting uterine leiomyomata may increase in size.

3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.

4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.

5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.

6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.

7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.

8. Serum folate levels may be depressed.

9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.

10. Certain endocrine and liver function tests and blood components may be affected.

(a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS

An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis, cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; benign hepatomas; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma; breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea, changes in appetite; cystitis-like syndrome; headache; nervousness, dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration

Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED

Norlestrin 21 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin 21 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin Fe 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin FE 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin 28 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

0901G131

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

© 1985 Warner-Lambert Company

PD-21-JA-2563-P-1(11-84)

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

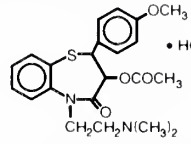
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CAROIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CAROIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CAROIZEM is indicated in the management of chronic stable angina. CAROIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CAROIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CAROIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CAROIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and AOVERSE REACTIONS.)

PRECAUTIONS

General. CAROIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CAROIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CAROIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CAROIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CAROIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Oegree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CAROIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where Southeastern Medical Data Systems comes in.

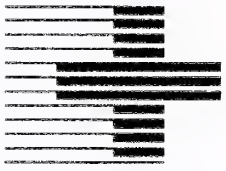
Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

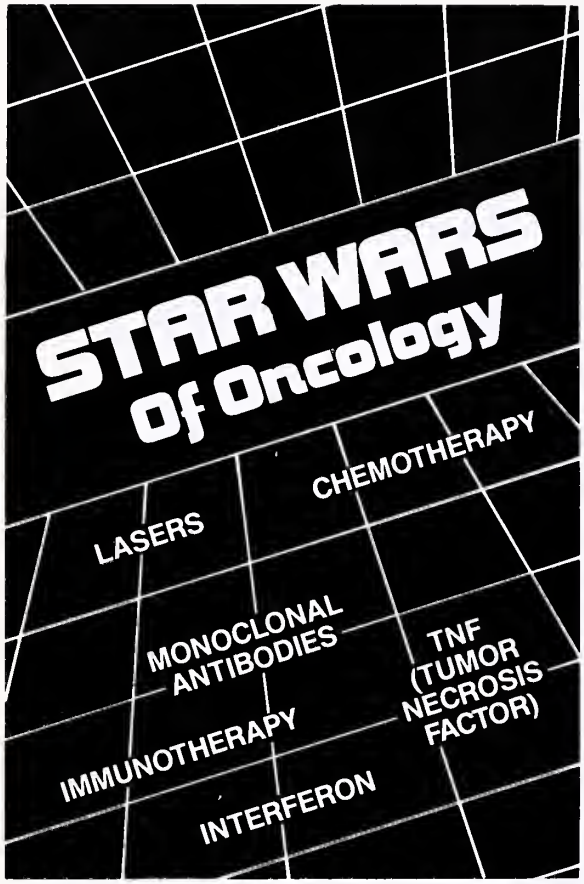
Write or call us for additional information and we'll get back to you immediately.

After all, we wouldn't want to try your patience.



southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792



STARS WARS of Oncology

★ Lasers
★ Chemotherapy
★ Monoclonal Antibodies

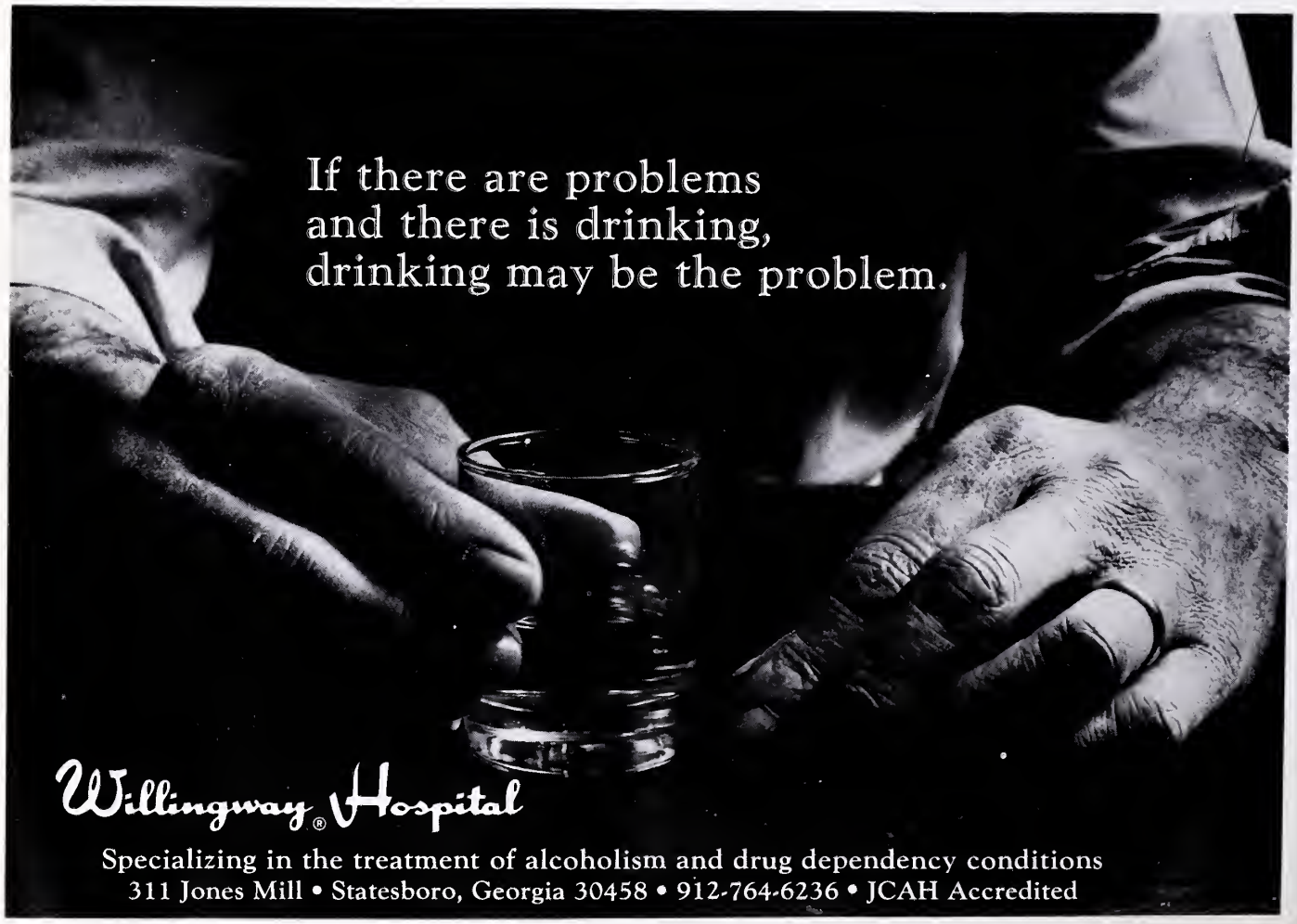
A one-day medical symposium presented by
South Highlands Hospital
Birmingham, Alabama

DATE: Friday, November 1, 1985
MEETING LOCATION: Birmingham Hilton
808 South 20th St.
Birmingham, Alabama

FEE: $65.00
Free for pre-registered residents
Free for medical students

FOR INFORMATION AND RESERVATIONS:
Call Mrs. Dena Metts
(205) 930-7703

Distinguished speakers to include, among others:
Richard M. Dwyer, M.D.—Laser Endoscopy Medical Group, Inc., Los Angeles, CA; Chief of Endoscopy, Harbor General Hospital, Terrance, CA; Associate Clinical Professor of Medicine, U.C.L.A.—"Management of CA of GI tract, bladder tumors, and pulmonary lesions."
Thomas C. Merigan, M.D.—Chief, Division of Infectious Diseases, Stanford University—"Immunotherapy of cancer in its broadest aspects. Interferon. Monoclonal antibodies."
John McDonald, M.D.—Chairman, Oncology Department, University of Kentucky—"Defense establishment of medicine . . . oncology. Recent developments in tumor therapy with emphasis on those tumors which are impressively benefited by therapy."



Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

The orange jackets

The scene was a crowded convention hall of the Drake Hotel in Chicago. It was the Annual Meeting of the American Medical Association Auxiliary. Over 350 officers, chairmen, delegates, and guests had gathered for this 62nd Annual Session. How to find anyone in this grand assembly could pose a problem, but not for the Florida Delegation. Each Florida delegate was quickly and joyfully recognized by her bright orange jacket.

All nineteen delegates were in high visibility at every function. They assisted with the activities of the Florida Medical Association and were there to help honor former FMA President, Rufus Broadaway, M.D., who is an AMA Trustee and President of the American Medical Association Education and Research Foundation.

It began with the roll call of states and ended with the Missouri reception honoring the newly installed AMA Auxiliary President, Mrs. William R. McPhee of Kansas City. The orange jackets were seen at reference committee hearings, and actively participated in the proceedings. They stood at attention and in pride to hear Immediate Past FMA Auxiliary President, Nancy Smith report on Auxiliary activities in legislative affairs, the Medi-File, the Governor's Committee on Aging, and in promoting the Research Center for Alzheimer's Disease.

The orange jackets were seen on stage accepting outstanding AMA Auxiliary awards for the best county newsletter in its category, Dade County, and for the best county newsletter in all the states, Dade County. Congratulations to Dade County and its editor, Emily Dabby!

For total contributions to AMA-ERF, the Florida Auxiliary was awarded second place, $112,354.39. First place went to California for a total contribution of $123,866.18. A check in the amount of $1,897,745.76 was presented to the AMA-ERF as the AMA Auxiliary contribution by the Auxiliary President, Mrs. Wayne C. Brady of South Carolina.



FMA-A Delegates to the AMA-A Annual Convention lead by Mrs. Laurin G. (Nancy) Smith, 84-85 President, and Mrs. Milton (Jo) Tignor, Chairman of the 19 Delegates.

Auxilians in the orange jackets were there to hear the keynote address on "Health Care in America" by Minnesota Senator David Durenberger; guest speaker, Uwe E. Reinhardt, Professor of Political Economy at Princeton on "The American Health Care Brawl: Will Anyone Win?" and to delight in the special symposium by noted author and lecturer, Florence Littauer on "How to Understand Others by Understanding Yourself." Political humorist, TV, radio and recording star, Mark Russell was the guest speaker at a luncheon honoring National Auxiliary Past Presidents and Honorary Members.

It was a busy time of meeting and learning, of friendship and fellowship. The orange jackets have been tucked away for another year, but the spirit of caring remains ever vigilant as the FMA Auxiliary moves forward in another year of showing that WE CARE.

Isabella Laude
Babson Park

No need for dosage calculations...



VERMOX®
(mebendazole)

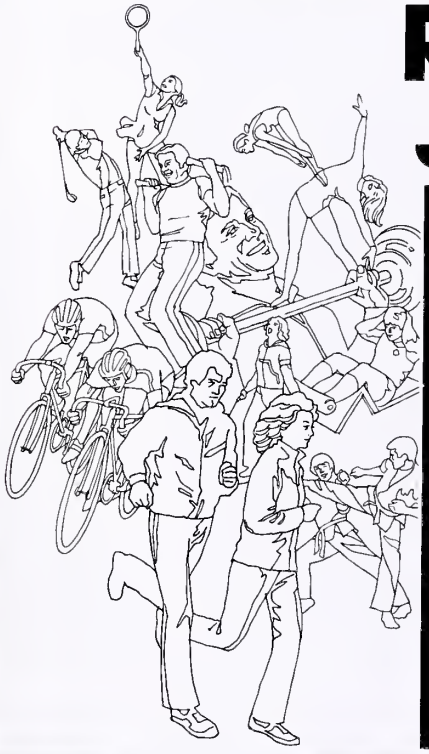
CHEWABLE TABLETS

JANSSEN PHARMACEUTICA
Piscataway, NJ 08854-3998

JPI-550

© Janssen Pharmaceutica Inc. 1985

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

AMC Grow Hill

Anatomy of Medical Malpractice and Risk Management
A Seminar on the Causes and Treatment By Nationally Recognized Attorneys and Physicians

Saturday and Sunday, September 7-8, 1985
James L. Knight Center, Miami, Florida

Sponsored by
The American Institute of Medical Law, Inc.

Approved for 17 hours AMA Category I Credit

Registration Fee: $295.00 (Includes Continental Breakfast and Keynote Speaker Luncheon daily

Program Chairman: Mickey Demos, M.D.

Speakers:

Edward Annis, M.D.
Henry Burnett, Esq.
Edward Corlett, Esq.
Raymond Dwyer, Esq.
Pepi Granat, M.D.
Murray Sams Jr., Esq.
J. B. Spence, Esq.
Charles George, Esq.
Richard Feinstein, M.D.

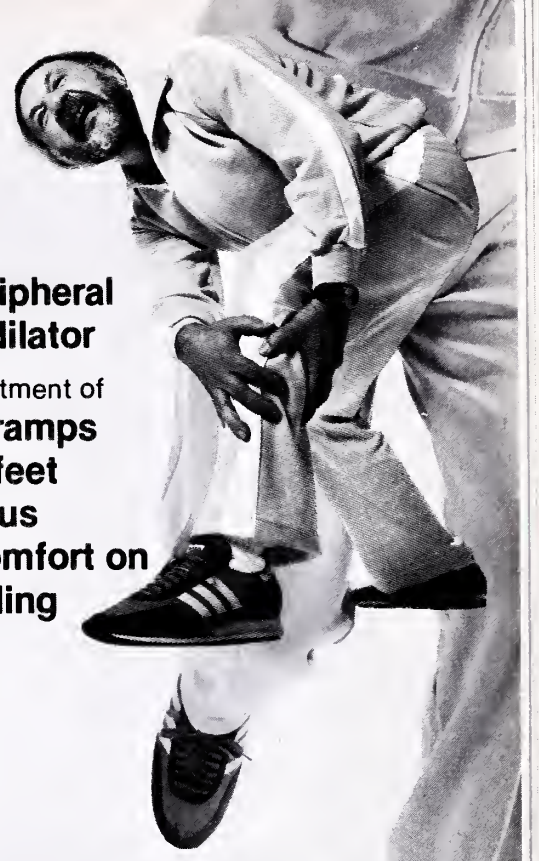
For more information contact:
Seminar Registration Office
6614 Miami Lakes Drive East
Miami Lakes, Florida 33014
Phone: (305) 687-1367

ANNOUNCING
Second Annual "Controversies in OB/GYN and All That Jazz"
October 3–4, 1985

Sheraton Jacksonville Beach Resort Inn
Presented by
BAPTIST MEDICAL CENTER

This in depth seminar will provide physicians and nurses with an opportunity to explore significant topics and challenging clinical problems encountered in the contemporary obstetrics/gynecology practice. Nationally known authorities will present current clinical advances and research findings.

For more information and registration, contact
Sheila Bobek, Continuing Education Department
Baptist Medical Center
800 Prudential Drive
Jacksonville, FL 32207
(904) 393-2080



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®
Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER PD

Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

SEPTEMBER

Current Concepts in the Management of Paln, Sept. 3, Holy Cross Hospital, Ft. Lauderdale. For more info: Joh Fichtelmar, M.D., 4725 N. Federal Hwy., Ft. Lauderdale, Fl. 33308. (305) 492-5728.

Physical Therapy Treatments/ Modalities, Sept. 10, Doctors' Hospital, Lake Worth. For more info: Roberto Miguel, M.D., 2889 9th Ave. N., Suite 203, Lake Worth, Fl. 33461, (305) 965-3280.

Anxiety — Quest for Improved Therapy, Sept. 11, Holy Cross Hospital, Ft. Lauderdale. For more info: Joh Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale, Fl. 33308, (305) 492-5728.

Current Concepts in the Management of Spina Bifida, Sept. 13-14, Sheraton St. Johns Hotel, Jacksonville. For more information: Carol Pitman, Nemour Children's Hospital, (904) 721-4230.

Annual Meeting of the Florida Assocation for Nutritional Support, Sept. 13-14, USF College of Medicine, Tampa. For more information: William Blackshear, M.D., 12901 N. 30th Street, Tampa, Florida 33612.

Current Concepts in the Diagnosis of Adult Heart Disease IV, Sept. 13-14, New World Inn, Pensacola. For more information: D. Bruce McGraw, M.D., P.O. Box 151, Pensacola, Fl. 32591-0151, (904)478-4121.

Calcium Channel Blocker Update, Sept. 13-15, Saddlebrook Resort, Wesley Chapel, Fl. For more info: Stephen Glasser, M.D., 12901 N. 30th Street, Tampa, Florida 33612.

Advanced Cardlac Life Support, Sept. 13-15, Marion Community Hospital, Ocala. For more information: Marion Community Hospital, Inservice Education Dept., 1431 S.W. First Ave., Ocala, 32671.

Clinical Essential in Cleft Lip and Cleft Palate, Sept. 19,University of South Florida, Tampa. For more information: David R. Dickson, P.O. Box 016960, Miami, Fl. 33101, (305) 547-6123.

Coronary Artery Disease, Sept. 20-21, PGA Sheraton, Palm Beach Gardens. For more information: Jo Ellen Brown, 3360 Burns Road, Palm Beach Gardens, 33410, (305) 622-1411, Ext. 518.

International Symposium on Gynecologic Oncology, Surgery and Urology, Sept. 23-27, Germany. For more info: William A. Little, M.D., Deparment of Obstetrics and Gynecology, P.O. Box 016960, Miami 33101, 305-549-6944.

Beta Blocker Therapy, Sept. 26, Indian River Memorial Hospital, Vero Beach. For more information: Candy May, 1000 36th Avenue, Vero Beach, Fl. 32960, (305) 567-4311.

Ninth Annual Medical Aspects of Aging, September 27-28, University of Florida, Gainesville. For information, call: Grace Wagner, JHMHC J-233, Gainesville 32610, (904) 392-3143.

Fractures of the Pelvis and Acetabulum, Ramada Renaissance Hotel, San Francisco, CA. For more information: Emile Letournel, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 974-3322.

OCTOBER

Treatment Options in Drug and Alcohol Abuse, Oct. 1, Holy Cross Hospital, Ft. Lauderdale. Contact: John Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale, Fl. 33308, (305) 492-5728.

Medicolegal Issues in Obstetrics, Oct. 3-6, New York City, N.Y. For more info: Robert Kruppel, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, (813) 251-3748.

The Professional and Chemical Dependency, Oct. 4, New World Landing, Pensacola. Contact: Brunie Emanuel, Route 2, Box 174, Gulf Breeze, Florida 32561, 932-9375.

Laser Surgery Training Course, Oct. 8-11, Contemporary Resort Hotel, Orlando. Contact: Douglas Dew, M.D., 1414 S. Kuhl Avenue, Orlando, Fl., 32806, (305) 841-5144.

1985 Fall Conference on Pediatric Trauma, Oct. 11-12, Orlando Airport Marriott, Orlando. Contact: Joan H. Pyle, Dept. of EMS, P.O. Box 1393, Orlando, Fl. 32802, (305) 420-3188.

1985 TNO-ISIR Meeting on the Interferon System, Oct. 13-18, Holiday Inn, Surfside, Clearwater. Contact: William Stewart, 12901 N. 30th Street, Tampa, Fl. 33612, 813-974-2178.

Eleventh Annual PanAmerican Seminar, Oct. 14-18, Mount Sinai Medical Center, Miami Beach. For more info: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Calcium Channel Blockers New Concepts, Oct. 16, Lincoln Hotel, Tampa. Contact: Stephen Glasser, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 974-2880.

Advanced Neuroradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

First Annual Conference on Clinical Problems in Primary Care, Oct. 18, USF College of Medicine, Tampa. Contact: Joseph Finster, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 974-4296.

Third Annual Meeting of the Vitreous Society, October 23-26, Contemporary Hotel, Lake Buena Vista. Contact: W.S. Grizzard, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, 813-875-6373.

Pain Management Conference, Oct. 24-26, Royal Plaza Hotel, Orlando. Contact: Marge Duchano, R.N., Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando, Fl. 32806, (305) 841-5144.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Fall 1985 Family Practice Review, Oct. 27-Nov. 2, Orlando. Contact: Grace Wagner, JHMHC, J-233, Gainesville, Fl. 32610, (904) 392-3143.

Ninth Annual Medical Aspects of Aging, October 27-28, University Centre Hospital, Gainesville. For information: James A. Jernigan, M.D., JHMHC-J-233, Gainesville, 32610, 904-392-4321.

Fall 1985 Family Practice Review, Oct. 28-Nov. 1, Palace Hotel, Lake Buena Vista. For information: Lamar Crevasse, M.D., JHMHC J-233, Gainesville, 32610, (904) 392-3143.

Clnical Applications for Pulsed, Continuous Color Flow Doppler Echocardiography, Oct.31-Nov. 1, Mount Sinai Medical Center, Miami Beach. For information: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., 12901 N. 30th Street, Box 15, Tampa 33612, 813-974-4214.

11th Annual S.E. Conference on High Blood Pressure, Oct. 30-Nov. 1, Las Palmas Inn, Orlando. Contact: James C. Bailey, 1317 Winewood Blvd., Tallahassee, Fl. 32301, (904) 488-2901.

NOVEMBER

Twenty-sixth Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Hotel, Clearwater. For information: Henry Marriott, M.D., 601 12th Street N., St. Petersburg 33705, (813) 894-0790.

Advanced Cardiac Life Support, Nov. 2-3, USF College of Medicine, Tampa. For more information: J. Paul Michlin, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 251-6911.

Spinal Deformities, November 3-6, Sheraton Bal Harbour, Bal Harbour. For information: Barry Silverman, 2050 N.E. 163rd Street, N. Miami Beach 33162, (305) 944-4746.

Current Advances in Perinatology, Nov. 3-9, Virgin Islands. Contact: Charles R. Bauer, M.D., Division of Pediatrics, P.O. Box 016960, Miami, Fl. 33101, (305) 547-5808.

Eleventh Annual Review Courses in OB/GYN, Nov. 13, Miami. Contact: Patty Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Third Annual Childrens Hospital Foundation — Care of the Sick Child, Nov. 14-16, Palace Hotel, Lake Buena Vista. Contact: Joseph Chiaro, M.D., 1414 S. Kuhl Ave. Orlando, Fl. 32806, (305) 841-5143.

Eleventh Annual OB/GYN Reveiw Courses, Nov. 14-25, Sheraton Royal Biscayne Hotel, Key Biscayne. Contact: Patti Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Ninth Annual Seminar: Evolution in the Total Care of the Pediatric Hematology/Oncology Patient, November 21-23, Hyatt Orlando, Orlando. For information: Cindi Butson, P.O. Box 13372, University Station, Gainesville 32604, 904-375-6848.

DECEMBER

Techniques of Therapeutic Gastrointestinal Endoscopy, December 4-6, Contemporary Resort Hotel, Lake Buena Vista. For info: H. Worth Boyce Jr., M.D., USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612 (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation II: Technology and Techniques, Dec. 4-8, Sheraton Bal Harbour, Miami. Contact: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, (305) 547-6716.

Clinical Allergy and Immunology for the Practicing Physician, Dec. 5-7, Palace Hotel, Lake Buena Vista. For info: Richard F. Lockey, M.D., VA Hospital, 13000 N. 30th St., Tampa, 33612, (813) 972-2000, ext.596.

Theoretical and Clinical Considerations Affecting the Selection of Neuroleptic Agents, December 6-7, Boca Raton Hotel, Boca Raton. For information: Millie Toberts, P.O. Box 016960, Miami 33101, 305-549-6327.

Ear, Nose, & Throat Diseases in Children, December 7-11, The Breakers, Palm Beach. For information: 125 DeSoto Street, Piladelphia, PA 15213, 412 647-5466.

Emergencies in Internal Medicine, VIII, Dec. 8-14, St. Thomas, Virgin Islands. For more information: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, 305-547-6716.

New Approaches to Common Disorders II, Dec. 11-14, Clearwater Beach. For information: Joel Gleason, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 397-5511.



THE APPROPRIATE GIFT FOR AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Send the bill for $15.00 (add .75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____

The AMA Announces...

20 NEW PATIENT MEDICATION INSTRUCTION SHEETS

Now there are 60 PMIs available to help educate your patients about the drugs you prescribe for them

Your patients want to know!
Your patients need to know!
Now you can contribute to better patient education by distributing PMI sheets. PMIs are handy, tear-off drug information sheets that are meant to supplement your verbal instructions to your patients.

PMIs help to improve compliance, strengthen your relationship with your patients, and reduce the number —but enhance the importance—of the call backs you receive.

Quick, simple, balanced drug information

PMIs contain scientifically sound information regarding the drugs you most frequently prescribe. To prevent confusion, particular care has been taken to make PMIs easy-to-understand and easy-to-read. To avoid needlessly alarming the patient, PMIs do not list all adverse drug reactions or less well-documented and rare reactions.

Benefits you and your patients

It is the proper and vital role of the physician to provide drug use information to patients. While face-to-face counseling is an indispensable part of patient education, counseling supplemented by written information has been shown to be the most effective.

PMIs help to improve patient compliance, strengthen your professional relationship with your patients, and reduce the number—but enhance the importance—of the call backs you receive.

ORDER YOUR PMIs TODAY!

Complete this order form and mail it with your payment to:

PMI Order Dept.
American Medical Association
P.O. Box 8052
Rolling Meadows, IL 60008

(Please print)

Name _____

Address _____

City _____

State/Zip _____

Number of pads	PMI Number and Title
_____	027 Allopurinol
_____	018 Belladonna Alkaloids and Barbiturates
_____	012 Benzodiazepines
_____	004 Beta-Blockers
_____	009 Cephalosporins—Oral
_____	032 Chloramphenicol—Oral
_____	017 Cimetidine
_____	031 Clindamycin/Lincomycin—Oral
_____	016 Corticosteroids—Oral
_____	006 Coumarin-Type Anticoagulants
_____	005 Digitalis Medicines
_____	034 Ergot Derivatives
_____	010 Erythromycin
_____	026 Ethosuximide
_____	001 Furosemide
_____	024 Guanethidine
_____	022 Haloperidol
_____	023 Hydralazine
_____	035 Indomethacin
_____	015 Insulin
_____	038 Iron Supplements
_____	033 Levodopa/Carbidopa and Levodopa
_____	021 Lithium
_____	014 Methyldopa
_____	030 Metronidazole
_____	040 Nifedipine
_____	013 Nitroglycerin Sublingual Tablets
_____	011 Nonsteroidal Anti-Inflammatory Drugs
_____	007 Oral Antidiabetes Medicines
_____	003 Penicillins—Oral
_____	036 Phenylbutazone/ Oxyphenbutazone
_____	019 Phenytoin
_____	037 Quinidine/Procainamide
_____	020 Sulfonamides
_____	008 Tetracyclines
_____	002 Thiazide Diuretics
_____	029 Thyroid Replacement
_____	025 Valproic Acid
_____	039 Verapamil
_____	028 Xanthine Derivatives—Oral
NEW PMIs now available!	
_____	049 Acetaminophen
_____	050 Amiloride and with Thiazide
_____	043 Antihistamines
_____	047 Aspirin
_____	044 Bronchodilator Aerosols
_____	054 Clonidine
_____	048 Codeine
_____	056 Diphenoxylate with Atropine
_____	057 Isotretinoin
_____	059 Methotrexate (for psoriasis)
_____	055 Methysergide
_____	045 Pentazocine—Oral
_____	041 Phenothiazines
_____	058 Potassium Supplements
_____	052 Prazosin
_____	046 Propoxyphene and with Aspirin or Acetaminophen
_____	053 Spironolactone and with Thiazide
_____	060 Steroid and Antibiotic Eye Drops
_____	051 Triamterene and with Thiazide
_____	042 Tricyclic Antidepressants
_____	Total number of pads (5 pad minimum, 50 PMIs per pad)
$ 1.00	Per pad
$ _____	Subtotal
$ _____	Residents of IL and NY must add appropriate sale tax to subtotal
$ _____	Total payment (check enclosed)

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

PRIMARY CARE FACILITY in West Palm Beach seeking part time physicians for hourly work, and full time positions for future facilities. Send CV to: Administrator, P.O. Box 25986, Tamarac, FL 33320.

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE OR EMERGENCY MEDICINE physician opening in a private freestanding emergency center. Excellent location. Highly attractive practice setting. Send CV to: Michael J. Webb, M.D., Harrell Medical Center, 1805 SE Lake Weir Avenue, Ocala, FL 32627 or call (904) 629-0642.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

GENERAL INTERNISTS, PEDIATRICIANS, AND NEUROLOGISTS: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

PRIMARY CARE CENTERS in Florida: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full-time basis. Positions available in central and south Florida coastal communities. Excellent opportunity - guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 S. Harbor City Blvd., Suite 307, Melbourne, Florida 32935.

EXPERIENCED, BOARD CERTIFIED SPECIALISTS in orthopedics, neurosurgery/neurology, and EMG wanted for part time association with office based group performing medico-legal evaluations in Dade and Broward Counties. We offer excellent renumeration with no nights or weekends on call, and minimal malpractice exposure. Call (305) 557-0900 or send C.V. to Medical Director, Southern Diagnostic Associates, Inc., 1575 West 49th Street, Suite 132, Hialeah, Florida 33012.

PRIMARY CARE PHYSICIANS to associate with Free Standing Walk-In Center, some ER experience helpful. Please send CV or contact Jensen Beach Emergi-Centre, 1801 NE Commercial Street, Jensen Beach, Fl 33457, (305) 334-1700.

FAMILY PHYSICIAN TO JOIN busy internist in Florida Keys. Office has laboratory, EKG and X-ray capabilities. Will provide very flexible association to the right individual. Send CV to: Robert Carraway, M.D., P.O. Box 2008, Key West, FL 33040 (305) 294-0511.

FAMILY PHYSICIAN wanted to join busy internist in the Florida Keys., Flexible association available to the right individual. Write: Medical Clinic, P.O. Box 2008, Key West, Florida 33040.

BOARD CERTIFIED OR QUALIFIED FAMILY PHYSICIAN: Looking for a rewarding practice with a controlled work schedule, plus ample time for teaching and CME? Position available in Family Practice Center, Family Practice Diagnostic Center and Geriatric Diagnostic Center of large teaching hospital. Scope of duties flexible dependent upon interest in teaching. Faculty appointment, University of Florida. Competitive salary, excellent fringe benefits and retirement plan, exceptional recreation and cultural activities. Send CV to: John A. Grisnik Jr., M.D., Department of Community Health and Family Medicine, University Hospital of Jacksonville, 655 West 8th Street, Jacksonville, Fl. 32209.

UROLOGIST — Florida southeast coastal Urologist Board Certified or eligible. American trained. To join clinic of 20 board certified and subspecialty certified internists. Academic stimulus. No limit to earnings. Beautiful area. Excellent life style. Reply with CV to C-1290, P.O. Box 2411, Jacksonville, Fl. 32203.

GYNECOLOGIST: Florida southeast coastal area Gynecologist Board Certified or eligible. American trained. To join clinic of 20 board certified and subspecialty certified internists. Academic stimulus. No limit to earnings. Beautiful area. Excellent life style. Reply with CV to C-1290, P.O. Box 2411, Jacksonville, Fl. 32203.

INTERNIST — Florida southeast coastal area Internist Board Certified or eligible. American trained. To join clinic of 20 board certified and subspecialty certified internists. Academic stimulus. No limit to earnings. Beautiful area. Excellent life style. Reply with CV to C-1290, P.O. Box 2411, Jacksonville, Fl. 32203.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

WANTED — INTERNIST with interest in cardiology or rheumatology. Opportunity available in beautiful lakes and hills of Central Florida, 25 miles north of Orlando. In established fully equipped clinic, lease with later option to buy. Close to 150 bed hospital which will guarantee adequate income first year. C-1270, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPAEDIC SURGEON — wanted to join an established surgeon, southeast Florida, Boynton Beach area. Send CV: C-1279, P.O. Box 2411, Jacksonville, Fl. 32203.

WANTED: IM, FP, OR GP to share furnished and fully equipped office building with General Surgeon, Orthopaedic Surgeon, Family Practitioner and Gynecologist. Location established 35 years. Adjacent to major hospital diagnostic center in North Miami, Florida. Facilities include X-Ray, Minor Surgery, EKG, computerized billing and insurance. Send CV to office manager, 12996 W. Dixie Hwy., N. Miami, Fl 33161, (305) 891-6589.

POSSIBLE OPENING FOR UROLOGIST. Established practice in Naples, Fl. All you need in one package. Call (813) 262-3996 or (813) 262-1521 for further information.

WANTED: PHYSICIANS IN ALL SPECIALTIES to review medical records — send your CV to Miss Wagda, 319 Harwich Road, Brewster, Mass. 02631.

FAMILY PRACTIONER: Immediate opening for primary care physician seeking a challenge. Expanding 153-bed acute care hospital in Correctional setting offers professional growth opportunities. If interested in more hands-on patient care, please call Dr. John E. Metheny at (904) 496-2222 (ext. 121) or send CV to: Personnel Office, Reception and Medical Center, P.O. Box 628, Lake Butler, Fl. 32054-0628.

MEDICAL EXECUTIVE DIRECTOR needed for the Office of Disability Determinations. Assists in policy guidance and oversees medical evaluations. No patient contact. Previous administrative and/or medical disability program experience desirable. Florida license required. Equal Opportunity Employer. Salary: $51,991.20 to $91,851.12. Contact Robert Rumbley, PR Coordinator, Disability Determinations, HRS, 2600 Blairstone Road, Tallahassee, Fl. 32301 (904-488-6369).

WANTED: CARDIOLOGIST for Palm Beach County/Delray Beach area — immediate opening in active medical center. Early opportunity to join firm. Call Irv Herman, 305-499-5252, or write C-1281, P.O. Box 2411, Jacksonville, Fl. 32203.

EMERGENCY PHYSICIAN needed for independant group at new Gulf-coast hospital. Expected income over $100,000. Send CV to C-1285, P.O. Box 2411, Jacksonville, Fl. 32203.

FAMILY PRACTICE OR EMERGENCY MEDICINE physician needed for established walk-in clinic in Tallahassee. Call Jay Maggiore, M.D., (904) 234-8492.

ORLANDO: Active 4 man ob-gyn practice seeks association with motivated compassionte BE/BC ob-gyn leading to partnership. Affiliated with large rapidly expanding referal center. The community is young and thriving. Send CV to The Ob-Gyn Group, 2905 McRae Ave., Orlando, Fl. 32803, Attn: Howard Schechter, M.D., 305-898-7151.

FAMILY PHYSICIANS for Family Practice Acute Care Wellness and Sports Center, integrated Jacksonville's best beach area. An unusual situation. Join three certified family phys., nutritionist, psychologist, exercise physiologist, phypsical therapist, in practicing the ultimate in family medicine. Uniquely integrated program of acute care, family practice, and total health care. Physicians who join us will have options of becoming a part of management quickly. Stable population, little tourism, and a great place to live at the ocean. Leisure life style. Twelve minutes from Jacksonville. Lots of time off. Cont. ed. is a requirement. Any residency-trained family physician would be proud to be associated with this practice. Practice is 3 years old. Contact. L.E. (Bruno) Masters, M.D., 100 Royal Palm Dr., Atlantic Beach, Fl. 32233, or call collect, (904) 241-5107.

PLASTIC SURGEONS — Excellent opportunity for Board Eligible/Certified surgeons for professionally and financially rewarding practice opportunities in various Florida locations. Reply to C-1284, Box P.O. 2411, Jacksonville, Fl. 32203.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

COME TO PARADISE: Rewarding primary care practice in Key West, Florida. Join the Island Clinic Group. Phone 305-294-4657. Ask for John Buckner.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

PHYSICIANS: Progressive, physician-owned medical group has positions available in the SE Florida area. Experienced, Board-prepared or Board certified physicians are preferred with interests in primary care, internal medicine, emergency and critical care medicine. Competitive salary, fringe benefits, paid malpractice insurance. Call (305) 325-1381 or send CV to Emergency Medical Group, P.A., 1400 NW 12 Ave., Miami, FL 33136.

FAMILY PHYSICIAN, Board certified, to join a well established solo practice in Central Florida. Initial salary with early opportunity for partnership. For further information, please call (813) 859-2748.

WORKING MEDICAL DIRECTOR wanted for outpatient walk-in center. Private practice opportunity on Florida Gulf Coast. Available immediately. Financial renumeration based on % of gross receipts. Respond with resume including phone number to Medical Clinic, P.O. Box 25312, Tampa, Fl 33622.

PEDIATRICIANS: Expanding pediatric group in western Palm Beach County seeking board eligible or certified Florida licensed physician for full time position in private/clinic practice. Excellent benefit package, competitive salary, future partnership opportunity to the right individual. Respond with CV to: Rodney Young, M.D., P.O. Box 182, Pahokee, Fl. 33476 or call (305) 924-5444.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only. C-1289, P.O. Box 2411, Jacksonville, FL 32203

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

OPHTHALMOLOGIST, BC/BE, to join very busy solo ophthalmologist. North Central Florida. Good hunting, fishing, boating, near ocean. Industrial, tourist, retirement area. Could gradually assume practice as Senior Partner slows down. Contact: P.O. Box 17038, Jacksonville, Fl. 32216.

QUALITY ASSURANCE DIRECTOR: Growing national leader in correctional health care is seeking a quality assurance director to be responsible for implementing and coordinating all aspects of theQuality Assurance Program of a 153 bed prison hospital. The successful candidate must possess strong clinical and leadership skills and must be knowledgeable regarding the specific functions of QA committees and the requirements promulgated by JCAH for accreditation. Requirements are BSN; MSN preferred, and recent experience as a Q.A. Director. Salary is competitive and commensurate with experience. E.O.E. For more information submit curriculum vitae to: Ms. Patty Martinell, MSN, Acting D.O.N., Reception and Medical Center, P.O. Box 628, Lake Butler, Fl. 32054.

EMERGENCY MEDICINE: Practice in beautiful Palm Beach County. Physicians needed for new group staffing two hospitals. Full or part time. Prefer BE or BC but will consider if experienced. Excellent compensation and malpractice insurance. Contact with CV: Medical Director, P.O. Box 273503, Boca Raton, Fl., 33427.

DIRECTOR OF NURSES: National Health Care Organization is seeking a strong administrative candidate for a Director of Nursing position in a 153 bed correctional hospital located in Lake Butler, Fl. This is an exciting opportunity for a person interested in a challenging position. The successful candidate must possess strong administrative skills and recent experience as a DON or Assistant DON. Salary is competitive and commensurate with experience. E.O.E. For more information, submit curriculum vitae to: Ms. Patty Martinell, MSN, Acting D.O.N., Reception and Medical Center, P.O. Box 628, Lake Butler, Fl. 32054.

PSYCHIATRIST: Director for inpatient Geriatric Program, plus private practice guarantee and office space provided. Requires specialized training and/or experience in management of inpatient geriatric program. Board certification strongly preferred. Send CV or call: Palmview Hospital, 2510 North Florida Ave., Lakeland, Fl. 33805, (800) 282-3480.

CARDIOLOGIST/INTERNIST: Florida southeast coastal area. Board certified or board eligible. American trained to join subspecialty oriented practice of 20 physicians. Experience in hemodynamic monitoring, noninvasive diagnostic techniques, pacemaker insertion, cardiac rehabilitation. Reply with CV to C-1290, P.O. Box 2411, Jacksonville, Fl. 32203.

PHYSICIAN — APPLICATIONS are invited for attending physician in local medical center. Duties include management, care and treatment of patients. Primarily family care and internal medicine but also including handling of emergencies. Hours will vary and include some weekend and night duty. Must be licensed to practice medicine in the State of Florida. Forty hours per week. $62,000 per annum. At least 4 years training In family practice or internal medicine. Submit resume to Job Service of Florida, 2217 Kingsley Avenue, Orange Park, Fl. 32073.

EXCITING OPPORTUNITY for Florida, American Schooled, licensed internist, general practitioners, and/or emergency room physicians on Florida's Treasure Coast. Send C.V. and references to Joemax Smith, Insta-Med Clinics, 1360 U.S. #1, Suite 6, Vero Beach, Fl. 32960.

Situations Wanted

BOARD CERTIFIED PEDIATRICIAN, Florida licensed, seeks group practice in Florida. C-1227, P.O. Box 2411, Jacksonville, Fl 32203.

LOCUM-TENENS: Radiologist, Board Certified, 53, academic and administrative experience, does most modalities, will also consider permanent association. Please write Box C-1265, P.O. Box 2411, Jacksonville, Fl. 32203.

BOARD CERTIFIED INTERNIST, Florida licensed, looking to join solo or group primary care practice on east coast. Available immediately. Reply: Charles Gelfman, 123-33 83rd Ave., Apt. 1605, Kew Gardens, N.Y. 11415 or call evenings (718) 544-9662.

D.O. WITH 9 YEARS EMERGENCY ROOM EXPERIENCE seeking position in urgent care center or E.R. in S.E. Florida Keys. Reply C-1286, P.O. Box 2411, Jacksonville, Fl. 32203 or call (616) 845-7620.

M.D. ANST, BC seeking a position, locum tenens, however sharing a full-time with a colleague is most desirable. Experienced ER physician, active ACLS, in the process of taking the ABEM seeking a position in moderate vol ER with some trauma. C-1288, P.O. Box 2411, Jacksonville, Fl. 32203.

PEDIATRICIAN, B/E, U.S. trained, Florida licensed. Has completed one year of Pedi Heme Ione fellowship. Looking for general pediatrics opportunity in South Florida. Will join solo practitioner or group. Helen Mitchell, M.D., 840 Madrid St., Miami, Fl. 33134, 305-447-0486.

VASCULAR GENERAL SURGEON. Vascular surgery fellowship. Board Certified. Four years private practice, desires multi-specialty group practice. C-1282, P.O. Box 2411, Jacksonville, Fl. 32203.

RADIOLOGIST, ABR, excellent qualifications, all modalities, presently staff in major West Coast teaching center, seeks quality practice position. Consider initial part-time or locum arrangement. C-1283, P.O. Box 2411, Jacksonville, FL 32203.

AMERICAN BOARD OF EMERGENCY MEDICINE, certified. Seeking position full time or part time in Palm Beach or Broward County. Six years experience as Director of a Department in a 250 bed hospital. ACLS and ATLS. Will consider also administrative position with private organization. Please contact M.D. 22751 Pinewood Court, Boca Raton, Fl. 33433.

PULMONOLOGIST: Fellow College of Chest Physicians, License: Conn., Mass. Resigned position of senior physician, Holley State Hospital, Florida. Age 75 years. Seek Administrative job. Call (305) 585-2832. Write 3460 S. Ocean Blvd., Palm Beach, Florida 33480.

Practices Available

INTERNAL-MED, FAMILY Practice est. 30 years for sale. Eager to retire. No reasonable offer refused. No cash needed for physician just completing residency. Five local hospitals require Board Eligible. Write Medical Center, P.O. Box 7603, West Palm Beach, FL 33405.

FAMILY PRACTICE available, 30 minutes from Gainesville, 50 minutes from Jacksonville, Fl. With all equipment. 904-964-6701.

MEDICAL OFFICE, street level, located in surfside, M.B., Fla., closest to all tourist hotels and permanent residences, in the center of Bal Harbor shopping area. Fully equipped and furnished. Best offer. 9-3 p.m., 866-8384; after 6 p.m., 866-3634.

FAMILY PRACTICE, Sarasota: active solo practice, with call group. Five years old. Resuming military career, personal reasons. Board Certified/Eligible, please. 1125 sq. ft. with reasonable renewable lease. $200,000 plus, annual gross. $99,000, negotiable. Contact Mike McBride, 813-955-3225.

INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

OPHTHALMOLOGY PRACTICE for sale — Location: Northeast Florida. Gross $500,000±, potential move, room for two. Building 4200 sq. ft. over 20 exam, treatment work rooms, busy optical shop. One-half acre corner lot. Hospital one-half mile. Contact C-1276, P.O. Box 2411, Jacksonville, Fl. 32203.

CENTRAL FLORIDA. 30-year busy B.C. family practice. Two-man building/land. Need associate, B.C., share expenses, to introduce into practice. Ultimately lease or purchase. C-1280, P.O. Box 2411, Jacksonville, Fl. 32203.

FOR SALE: DERMATOLOGIC PRACTICE. Fully-equipped and beautifully furnished offices in prestigious building. Ideally located in West Palm Beach, Fl. Could stay on one year or longer to assist in turnover. Great opportunity. Reply C-1287, P.O. Box 2411, Jacksonville, Fl. 32203.

Real Estate

DECORATED OFFICE SPACE AVAILABLE in the beautiful Lighthouse Point Professional Building at 2211 NE 36 Street, Lighthouse Point, Florida. For details please call (305) 942-1444.

GAINESVILLE, Bellamy Forge, 3 BR, 2½ B, attached garage, condo with all amenities, mint condition, $56,500.00. (813)254-3412.

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

TALLAHASSEE: FOR RENT — Fully furnished office presently used as a dermatological practice. In beautiful medical park across street from new rehabilitation hospital and mid-way between two large hospitals. Call 904-877-3129 or 893-1385.

SHARE MED-SURG OFFICE. 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach. Three exam rooms, lab and business office. Call Patrick E. Callaghan, M.D., (305) 428-2420.

FAMILY PRACTICE FACILITY: 4500 square feet. Designed for 3 doctors. Near hospital. Rent $6.50 sq. ft. includes all utilities. Option to buy. Owner (305) 452-6450.

FOR LEASE, 1,500 square ft. Medical office, ideal location, Douglas Road in Altamonte Springs and North Orlando. Mini blinds and cabinets, reasonable rent, immediate occupancy. Phone (305) 862-0107.

SOUTH MIAMI MEDICAL ARTS BUILDING: All specialties. Adjacent to two hospitals. 1500 - 1800 sq.ft. Fully partitioned and carpeted. Reasonable rent. (305) 661-5147.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned medical instrumentation: EKG, Lab, Holter, scanners, 2 D. Echos, stress-test, etc. Contact: Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065, 305-972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write: Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2, Box 386 A, Adel, Georgia. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

HOLTER SCANNING AND INTERPRETATION nationwide. For offices or hospitals at very special rates. Includes cardiology interpretation, immediate phone reporting, etc. Special rates for hospitals, HMO's. Will provide recorder and arrange for your office to learn patient connection, quality, etc. For information call Pittsburgh Cardiovascular, (412) 372-2035. 2550 Mosside Boulevard, Monroeville, PA 15146.

Equipment

CLAY-ADAMS QEA Sodium Potassium instrument. $2,000 used. Call (305) 776-1950.

Meetings

THE THIRD ANNUAL ADVANCED NEURORADIOLOGY SEMINAR sponsored by the Departments of Radiology at the University of South Florida College of Medicine and Tampa General Hospital will be held in the Walt Disney World Village Hilton, October 16-19, 1985. The course will stress the more recent advances in NMR, CAT Scanning and Interventional Neuroradiology. Guest faculty will include Drs. Bradley, Daniels, Fitz, Hachinski, Michelsen, Modic and Vinuela. The fee is $340 for 16 Category I Credit hours. Call Charleen Kirissman 813/974-2538 for more information.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

Physicians' Confidential Assistance

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203
(904) 356-1571

American Diabetes Association

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.

CALL TODAY!

Florida Affiliate
(305) 894-6664

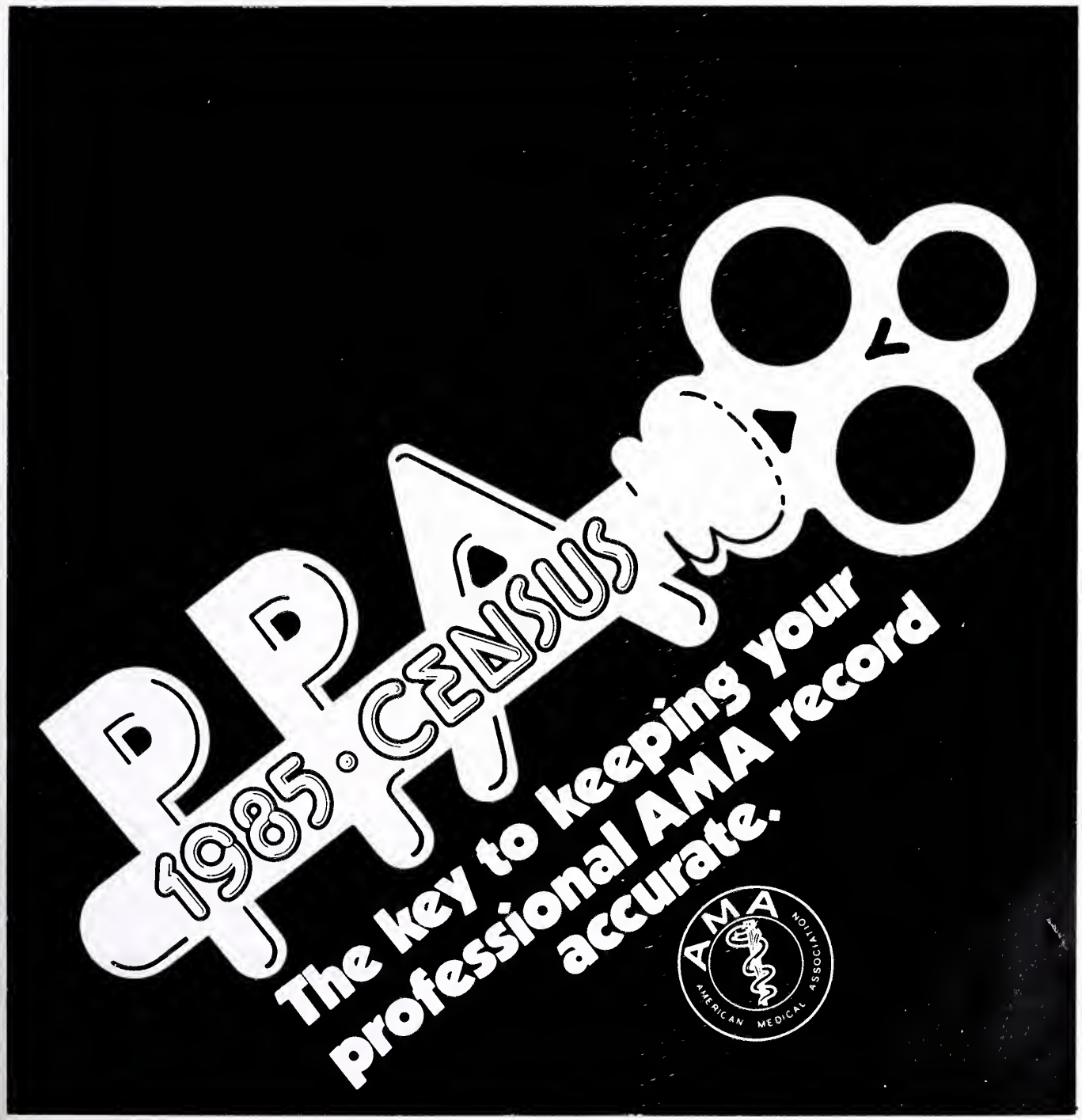
Physicians!
Plan to Participate When Your Census Form Arrives

Completing and mailing in your Physicians' Professional Activities Census form will ensure:

- That your professional record is updated on the AMA Physician Masterfile;
- That you are correctly classified by specialty and activity in the AMERICAN MEDICAL DIRECTORY;
- That you continue to receive educational and scientific materials relevant to your professional interests.

Call or write if you have not received a census form by April 1985:

Division of Survey & Data Resources
American Medical Association
535 North Dearborn Street
Chicago, IL 60610
(312) 645-5136



ADVERTISERS

Air Force
Recruitment 584

American Institute of Medical Law
Meeting 719

Army
Recruitment 694

Army Reserve
Recruitment 712

Baptist Medical Center
Meeting 719

BellSouth Mobility
Service 571

Brookwood Recovery Centers
Service 583

Brown Pharmaceutical
Android 570
Lipo-Nicin 710

Certified Medical Representatives Institute
Service 563

Curtis 1000 Information Systems
Computers 702

Eli Lilly & Company
Ceclor 711

Endocrine Society Postgraduate Assembly
Meeting 570

Florida Physicians' Insurance Reciprocal
Service 562

GTE Telenet
Service 582

Janssen Pharmaceutica
Vermox 718

Knoll Pharmaceutical
Isoptin 578b

Magnetic Resonance Imaging Center
Service 572

Marion Laboratories, Inc.
Cardizem 714c

Parke-Davis
Norlestrin 714a

Smith Kline Beckman
Dyazide 562g

Southeastern Medical Data Systems
Service 715

South Highlands Hospital
Meeting 716

Sports Medicine Journal
Publication 718

University of Alabama
Service 564

The Upjohn Company
Motrin 578a

Willingway Hospital
Service 716

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Director and C.E.O.

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

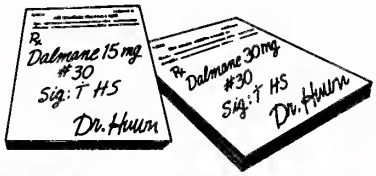
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓝ
sleep that satisfies

15-mg/30-mg capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. 3. Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. 4. Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. 8. Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
flurazepam HCl/Roche Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE®
flurazepam HCl/Roche ⓒ IV
sleep that satisfies



ROCHE

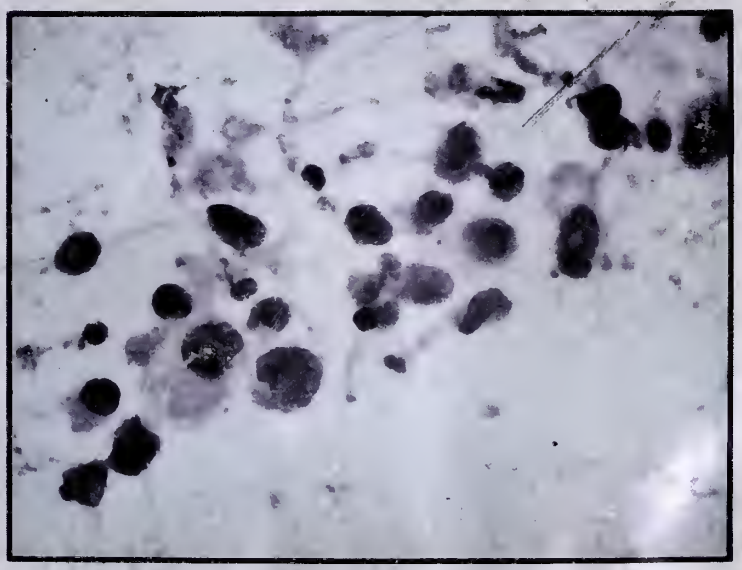
Copyright © 1985 by Roche Products Inc. All rights reserved.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION September 1985 Vol. 72, No. 9

SCIENCES
LIBRARY







Fine Needle Aspiration

IMPORTANT FEATURES



- Physician owned, controlled and directed.
- Managed by insurance professionals.
- Financially strong.
- Non-assessable.
- Competitive yet realistic rates.

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

New Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

Upjohn

The Upjohn Company
Kalamazoo, Michigan 49001 USA

© 1985 The Upjohn Company

J-5491 June 1985

Help her compute America's future.



Today, our children are computing basic math. Tomorrow, they'll be programming the future.

But before they can fill the computer screen with new information, we'll have to help fill their minds. With ideas. Information. Dreams. With the stimulation only a first-rate college education can provide.

But they'll need your help.

Because only with your help will colleges be able to cope with the high cost of learning.

Rising costs and shrinking revenues are threatening the ability of colleges to provide the kind of education tomorrow's leaders will need to solve tomorrow's problems.

So please give generously to the college of your choice.

You'll be programming America for success for years to come.

Give to the college of your choice.

COUNCIL FOR FINANCIAL AID TO EDUCATION INC
680 FIFTH AVENUE, NEW YORK, NY 10019
CFAE Ad Council
A PUBLIC SERVICE OF THIS PUBLICATION AND THE ADVERTISING COUNCIL

"I've had a successful practice for over 20 years. And I've seen a revolution take place. Technology and specialized medicine have enabled us to provide excellent care to our patients. Unfortunately, with it came high costs.

"Then the government stepped in and now we have pre-paid health care—the HMOs—and along with it, other alternative delivery systems. I've read predictions that say in the next five years, 25% of the U.S. population will be cared for under some sort of pre-paid program. So there's a lot of competition for those health care dollars and the pressure has a lot of people walking on eggs.

"On the positive side, there's a great opportunity out there. And I found it with Shari Medical Centers. They offer such an alternative delivery system in which a group of medical practitioners can remain independent and share in the profits resulting from reasonable cost control systems. For me, Shari's equity program really makes good sense, because when you have equity, you're building something for the future.

"What else can I tell you about Shari? The *first* Shari Medical Center is a four-story 54,000 square foot completely equipped total care medical facility in Ft. Lauderdale providing all administrative, management and marketing services.

"There's a lot more to tell you about Shari. If you'd like to know how you, too, can guarantee your future success in the rapidly changing health care industry, write to Shari Medical Centers, P.O. Box 291750, Ft. Laud., FL 33329 or call 305-726-3131."

Shari takes good care of you.

SHARI MEDICAL CENTER



"Shari showed me how to guarantee my future success in the rapidly changing health care industry."

—Dr. Frank McGee

For Cancer Consultation, Call a Specialist. MIST.



The University of Alabama Medical Center

The UAB Comprehensive Cancer Center was selected in 1973 as one of the first 11 comprehensive cancer centers funded by the National Cancer Institute. Today, the center is staffed by more than 135 member physicians and devotes more than $21 million annually to treatment and research of cancer.

The work of the UAB Comprehensive Cancer Center is carried on through five clinical divisions — Hematology/Oncology, Gynecologic Oncology, Radiation Oncology, Pediatric Hematology/ Oncology, and Surgical Oncology. Special services offered by the center include:

- **Estrogen and progesterone hormone assays for breast cancer.**
- **Lymphocyte markers for patients with leukemias and lymphomas.**
- **Immunogenetics screening (HLA typing).**
- **The use of the implantable drug infusion pump for continuous chemotherapy.**
- **Isolated limb perfusion for melanomas of the extremity.**
- **Interstitial irradiation for selected solid tumors.**
- **Laser Bronchoscopy.**
- **Combined modality treatment for lung cancer.**

The Cancer Center carries out clinical research in the diagnosis and therapy of various anemias, immune cytopenias and coagulation disorders. In addition to chemotherapy, the Center is studying the use of hyperthermia, monoclonal antibodies and the pharmacology of anticancer drugs.

The Comprehensive Cancer Center is one of 60 departments, divisions and centers of the University of Alabama Medical Center accessible to you through this service.

The Center welcomes physician inquiries. To speak with a physician, to consult about a patient, to refer a patient, or to request a patient transfer via the Critical Care Transport Service, telephone by using the MIST number.

MIST
Medical Information Service via Telephone

UAB University of Alabama Hospitals
University of Alabama at Birmingham

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC

SEPTEMBER 1985, Vol. 72, No. 9

CONTENTS

SCIENTIFIC ARTICLES

Jorge C. Arroyo, M.D., Frank M. Taylor III, M.D.	**761**	Thin needle aspiration biopsy as diagnostic tool: community hospital experience
John E. Davies, M.D., M.P.H., Carl D. Pfaffenberger, Ph.D.	**765**	Toxic environmental substances and concerns of their effects on public health
Robert C. Nuss, M.D. Guy Benrubi, M.D. and William Hazlett, Ph.D.	**768**	Risk factors for tumor recurrence after radical hysterectomy for Stage IB squamous cancer of cervix

SPECIAL ARTICLES

Thomas M. Daniel, M.D.and Robert W. Seligson	**773**	Hospital medical staffs: the future is now
Lee A. Fischer, M.D.	**777**	Health Maintenance Organizations and the Medicare program

EDITORIALS

R. G. Lacsamana, M.D.	**747**	Medical unions: the potential and the pitfalls
H. Frank Farmer, M.D., Ph.D.	**749**	A contract broken
R. G. Lacsamana, M.D.	**750**	The plague is spreading

LETTERS & VIEWPOINTS

Richard J. Feinstein, M.D.	**755**	Legal and ethical implications of joint ventures
James Scott, M.D.	**756**	Malpractice relief not on the way yet
William W. Schildecker, M.D.	**757**	Federal liability law needed

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1985 by Florida Medical Association, Inc.

COVER

This month's cover of *The Journal* demonstrates three aspects of thin needle aspiration: chest x-ray, instruments used, and cancer cells. The photographs were submitted by the authors of the lead article, "Thin Needle Aspiration Biopsy as Diagnostic Tool: Community Hospital Experience," Jorge C. Arroyo, M.D. and Frank M. Taylor III, M.D.

DEPARTMENTS

Luis M. Perez, M.D.	**741**	President's Page Tort reform through one body/one will
Jacques R. Caldwell, M.D.	**781**	Medical Economics Inquisition of the Medicare physician reimbursement system
	785	Notes and News
Leon Schiff, M.D..	**787**	Dean's Message Physician and patient
	788	Encores!
	791	Scam of the Month
	793	Book Reviews
Mrs. David S. Whittaker	**795**	FMA Auxiliary Marketing membership
	798	Meetings
	802	Classified Advertising
	810	Index to Advertisers
	811	FMA Officers and Council Chairman

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
Frank H. Farmer Jr., M.D., Ph.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Philip Altus, M.D.
Fuad S. Ashkar, M.D.
Thomas D. Bartley, M.D.
Pierre J. Bouis Jr., M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Mrs. Dale R. Charneco
Charles Craig, M.D.
R. Jay Cummings Jr., M.D.
Raul V. deVelasco, M.D.
Pablo Enriquez, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
James T. Howell, M.D.
Harold L. Ishler Jr., M.D.
Nicholas H. Kalvin, M.D.
Karl J. Kramer, M.D.
Jeffrey Lang, M.D.
Michael S. Levine, M.D.
Richard F. Lockey, M.D.
Mr. Dale Matza
Philander D. Morgan, M.D.
George Morris, M.D.
Richard S. Panush, M.D.
R.A. Penalver, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
Arvey I. Rogers, M.D.
William J. Romanos, M.D.
Hubert L. Rosomoff, M.D.
Lees M. Schadel, M.D.
Frederick W. Schert, M.D.
Jack J. Schneider, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Roberto A. Sosa, M.D.
Michael E. Steier, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victoria, M.D.
George Watkins, M.D.
Charles D. Williams, M.D.
Frederic C. Wurtzel, M.D.

CLINICAL ENDOCRINOLOGY UPDATE

Thirty-Seventh Annual

POSTGRADUATE ASSEMBLY
of The Endocrine Society

Sheraton Bal Harbour Hotel, Miami Beach, Florida

October 14-18, 1985

A comprehensive survey of the state-of-the-art in clinical endocrinology and its grounding in recent advances in the basic sciences and technology.

- Basic science overviews for the clinician
- Perspectives on the clinical applications of releasing hormones
- Current concepts of pathogenesis, diagnosis and management
- Assessments of recently developed imaging techniques
- Advances in the endocrinology of growth and of aging
- Clinical Vignettes: Difficult and Uncommon Endocrine Disorders
- Grand Rounds: Problem-Solving with Master Clinicians
- The Endocrine Family Picture Album
- Introduction to Computers (for registrants and guests)
- AMA Category I Credit

Tuition: $425.00 ($375.00 for trainees)

For registration and information write to:

Mrs. Nettie C. Karpin, Executive Director
The Endocrine Society
9650 Rockville Pike
Bethesda, Maryland 20814
Phone: (301) 530-9660

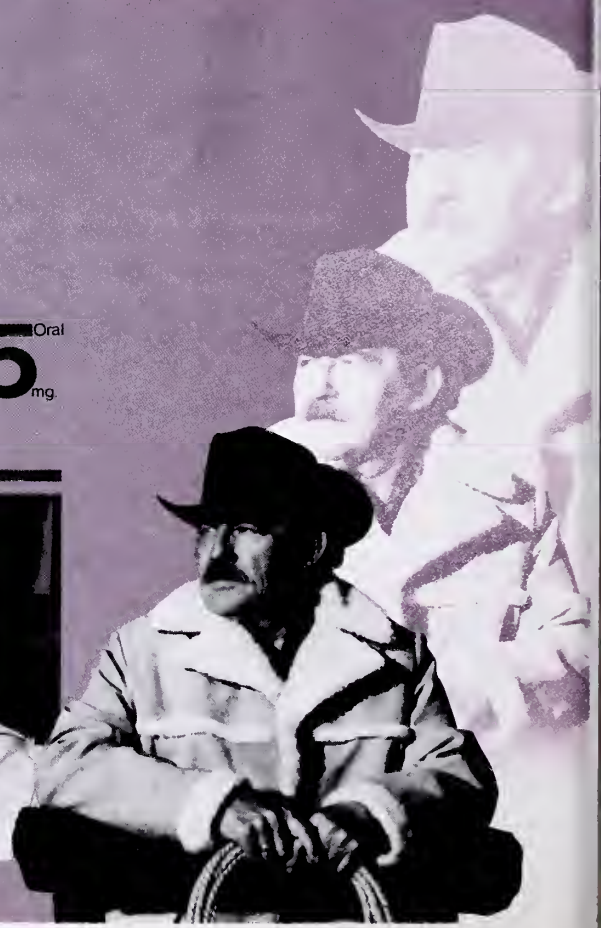
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Tort reform through one body/one will



The time has come to visit with your state representatives and senators. They are at home now, waiting and preparing for the next session of the legislature. This is your opportunity to find out what their feelings are in relation to the much needed liability reform.

As you all know, some advances were made in the last session, the first time in ten years. However, it was not nearly enough to ameliorate the problem permanently.

Your Council on Legislation is analyzing the issues very carefully and giving a lot of time and work to the political realities that we will have to face in the next session.

By now your local medical societies have received a letter asking the membership to meet with your legislators to ask them specific questions about the issues at hand. Their answers will help to give us a sense of direction for the future, help clarify the postures and positions we will have to adopt, and let us know the possibility of making further advances towards the resolution of the problems. The decision on which route to take will be made when all the data gained from the grassroots movement and the work of the FMA Committee on Legislation is analyzed. We expect to do so at the Board meeting in October.

Also, remember that the idea of another constitutional amendment, consisting of one issue, placed on the ballot is still being considered as a way to bring the liability problems out of our courts. The legislators' opinions on this subject should be evaluated as well.

In order to win this fight we have to be well organized and work as one body with only one will. Coalitions are being formed with other organizations that are as concerned with the liability crisis as we are. Preliminary conversations have been encouraging; old rivalries have been put aside so that a solid front can be made. All are going to work together during the coming months to create a positive, strong body aiming towards a common goal.

To achieve this goal we have to close ranks. We must realize that every physician must become a politician, as well as a public relations practitioner for the good of the profession as a whole. The Association's leadership, after weighing all the facts and evaluating all the possibilities, can give the necessary orientation and direction to our drive, but only after every physician gets rid of apathy, disinterest and critical cynicism towards our actions and becomes really committed to the work at hand, will we be successful.

The men of this world are divided into the ones that love and build and the ones who hate and destroy. We have to lay pettiness and personal motives aside. We have to possess enough strength and character to realize that bickering among ourselves is not constructive. We have to act together to solve the common serious problem that is facing us and with all our energy and determination fight for and solve it in the most logical, political and final form.

This does not mean that we completely ignore all the other issues at hand. The changes that are occurring in the delivery of medicine, the interference from other parties with our ability to provide the people of Florida with the best medical care available, and the inroads made by the Federal Government through Medicare and Medicaid to control our profession — these issues all must be kept on the front burner at all times, but in separate

compartments, separate burners if you will. They have different meanings to different people, and the majority of them must be worked out among ourselves. Some problems are national in scope; we must work with other states within the AMA policies before we can attempt a united form of action.

Liability is a common problem, not just to our profession, but to school boards, cities, counties, businesses and to any organization that has something to do with the protection of the people's right to have access to good services or medical care without fear of legal action against them.

Liability at this moment is the most serious threat not just to the medical profession, but to the people of Florida as well, and should be our primary concern. Each one of us should feel that the responsibility is on his shoulders. To change this threat we all have to work together with one body and one will.



The Logical Path to Compliance




BETA-
BLOCKER
Recommend
Step-1 ther
hypertension
DIURETIC
The addition of a diuretic
enhances the efficacy
of the beta-blocker.

IN HYPERTENSION END POINT:

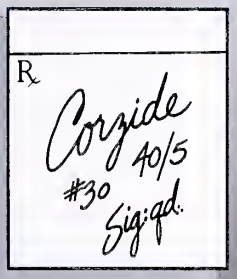
CONTROL, COMPLIANCE, CONVENIENCE

When hypertension control is complicated by the need for a beta-blocker plus a thiazide, CORZIDE® simplifies patient compliance with reliable once-a-day dosing in a single tablet.

CORZIDE®

(nadolol-bendroflumethiazide tablets)

Makes good sense



SQUIBB

Innovators in cardiovascular medicine

*Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure: The 1984 report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. Arch Intern Med 144:1045-1057, 1984.

Please see brief summary of prescribing information on following page

CORZIDE®

(nadolol-bendroflumethiazide tablets)

CORZIDE® 40/5
CORZIDE® 80/5
Nadolol-Bendroflumethiazide Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumathiazida** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — Cardiac Failure — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, amphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catecholamine stimulation of $beta_2$ receptors. **Mejor Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabates and Hypoglycemia** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g , tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: Generel — Nadolol — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiezide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide*, and PRECAUTIONS, *General, Bendroflumethiazide).*

Drug Interactions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery).* **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia).* **Catecholamina-depleting drugs (e.g., rasarpine)** — additive effect; monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbiturates, or narcotica** — may potentiate orthostatic hypotension. **Antidiabetic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertensiva drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking drugs** — potentiated effect. **Preanasthatic and anesthetic aganta** — effects may be potentiated; adjust dosage accordingly. **Preesor amines (e.g., norapinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide).*

Carcinoganeala, Mutageneels, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long-term studies in animals have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumathiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effecte** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nureing Mothere — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Padiatric Usa — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovescular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported; intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinel** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellenaoue** — Each of the following reported in 1 to 5 of 1000 patients: rash; pruritus; headache; dry mouth, eyes, or skin; impotence or decreased libido; facial swelling; weight gain; slurred speech; cough; nasal stuffiness; sweating; tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur: **Central Nervous Systam** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointastinal** — mesenteric arterial thrombosis; ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscelleneous** — reversible alopecia; Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiazide — Gastrointestinal System — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hemetologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermetologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovesculer** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treatment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bredycerdie** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cerdiec Failure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a $beta_2$-stimulating agent and/or a theophylline derivative. **Stupor or Come** — Supportive therapy as warranted. **Gastrointestinel Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormelitles** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult peckege insert before prescribing CORZIDE (Nedolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

© 1985 E. R. Squibb & Sons, Inc., Princeton, NJ 08540
505-502 Issued: March 1985

Medical unions: the potential and the pitfalls

The idea of trade unions among physicians is starting to stir new interest as the endless restructuring of the medical system continues unabated. More and more physicians are getting restless over developments that are slowly stripping away their independence and, in the process, displacing them as the guardians of medicine. The government has now become a very influential force in medicine; in addition, corporations, insurance companies, hospitals and an assortment of third parties have been continually amassing power and are now unabashedly wielding a big stick over the heads of physicians. While there is no collective panic yet, there is an increasing feeling of helplessness pervading the medical ranks which is impelling physicians to re-assert their voices. Trade unions, because of their promise of collective clout, hold a majestic appeal to many physicians.

Trade unionization in medicine never caught fire in the past simply because physicians were able to practice their profession unencumbered by government meddling or any third-party interference. But that picture has changed dramatically. This is a painful period for medicine, and unions thrive best in times of distress. Amidst the new era of competition spawned by the government, physicians are increasingly faced with the need to devise new practice strategies and to deal with an enlarging umbrella of HMOs, PPOs, IPAs, and what have you to maintain their base of patients and their incomes and, at the same time, preserve the good quality of medical care. Dealing with numerous third parties is a new rule of the game; to be able to bargain from strength is what physicians want.

Collective bargaining through trade unions has worked well for blue-collar workers, teachers, actors, pilots, and baseball players; there is no reason why it should not work equally well for physicians. At least that is the view of those who feel that the time for medical unions has come, including Dr. Sanford A. Marcus, who founded the Union of American Physicians and Dentists in 1972. Just to cite some obvious benefits, American trade unions have been able to bargain for better wages, better working conditions, better fringe benefits, and better retirement pay. The experience of Dr. Marcus's own union and of the medical housestaff unions in New York City, Chicago and Los Angeles, while limited, showed that collective bargaining for physicians could work. While it is true that the housestaff unions employed strikes to accomplish their goals, provisions were made to ensure that medical care was not denied to those with emergent or urgent medical needs. The same provisions can be made for future medical unions without the necessity of physicians having to strike.

The emergence of various health plans by a number of companies and corporations which offer contracts to physicians illustrates the complexities that the physician, as an individual practitioner, has to confront. Most physicians do not have the experience in dealing with third parties; even with guidelines offered by medical societies, physicians find it difficult to swim through the maze of intricacies, legal language, and fine print contained in a number of these contracts. These contracts contain provisions not only for physicians' fees, but for credentialing, board membership, peer and utilization review, pre-admission certification criteria, and disciplining as well. In effect, they can determine how physicians should practice medicine, which is a crucial issue for the profession. Individually, there is little that physicians can do to modify these contracts; collectively, through trade unions, they can

do a lot to obtain the benefits and other provisions of membership that they want.

While it is obvious that the benefits from a medical trade union are economic, there are other areas as well where they can help physicians. One of these is the lingering professional liability problem with the ever escalating malpractice premiums; medical unions, in concert with other medical organizations and other parties, can wield enormous influence in Congress and state legislatures to solve this problem once and for all. Another area, again in concert with established medical organizations, is in putting up a united front against the increasing encroachment of third parties in the practice of medicine, a development which has been slowly eroding the private practice of medicine. Other issues will emerge in the future where medical trade unions can be equally useful.

But why would physicians need trade unions when they have the AMA, the various state and county medical societies, and numerous other medical organizations that are already representing their interests? The answer lies in the anti-trust laws of this country. None of these organizations is permitted to engage in collective bargaining, or in any activity that will affect the reimbursement fees or policies of third-party carrieres. Court rulings against the Michigan State Medical Society and the Maricopa County Medical Society make this quite clear. Trade unions, on the other hand, are conferred immunity from the anti-trust laws. Dr. Sanford Marcus, the guru of the American medical union movement, made it clear, in a far-reaching article in the *New England Journal of Medicine*, that trade unions representing even independent practitioners can legitimately avail themselves of the same rights accorded unions established for salaried workers, positing the existence of an employer-employee relationship between physicians and other parties including Medicare, Medicaid, hospitals, HMOs and PPOs in their various interactions, and of a degree of control that one party exercises over another.

Appealing as the idea is of trade unions in medicine, there are many skeptics who do not think that unionization is the panacea that other physicians believe it is. History is on their side.

Trade unions, for one thing, are new, untested, and antithetical to the traditional roots and ideals of the medical profession. Notwithstanding current developments, there are still many physicians who strongly feel that medicine is not a business that should be tainted by unions. The service provided by physicians to their patients is unique; it is not similar to playing baseball, acting in a soap opera, unloading goods from the docks, or flying an airplane. The dignity of the medical profession must be maintained, unless physicians want to be treated like common workers or overpaid athletes who want to stuff their pockets even more. Trade unions, at least in this country, conjure up images of brazen and naked power, bullying tactics, strikes, rapacity, and corruption. How can we equate these images with medicine and its practitioners? Even with assurances that medical trade unions are not going to employ strikes and other dirty tactics, the public will perceive unionism as nothing more than a ploy for physicians to preserve their economic interests. A potential public backlash against the medical profession conceivably can do irreparable damage to physicians.

Furthermore, many physicians feel that those who are advocating medical trade unions are overreacting, and that their anxiety over their loss of control over their profession has no basis in fact. While it is true that the entrance of the government and other entities in medicine has made things different, physicians can still adjust to these realities without having to resort to unions. Economic realities may be harsher than they have been, but most physicians are still making a good living. The leverage through collective bargaining probably will not affect the policies of the government and other fiscal intermediaries which are bent on containing medical costs by every means. With or without medical unions, all indications point to diminishing incomes for all physicians. Comparatively, however, physicians' incomes are still among the highest for various professional groups.

One argument being bandied about in favor of unions is that physicians are steadily losing control of their profession and finding it increasingly difficult to deal with the government, corporations, hospitals, and other third parties. Unions may not necessarily mean that they will regain control. Physicians have little or no experience in union activities; conceivably, they will turn to labor professionals to run their unions but that may not sit well with those who know the labor movement in this country. The history of American labor leadership is not exactly replete with examples that will quell the fears of physicians who want to put their trust in these labor leaders. The scenario would be that of old emperors wearing new robes.

Finally, trade unions as an instrument of collective bargaining for independent medical practitioners, as opposed to salaried physicians under employ by an organization, still pose a problem in the thorny area of anti-trust activities. The courts have ruled clearly that any activity by a group of physicians that has the effect of influencing fee structures is in restraint of trade and therefore a violation of the anti-trust statutes. Proving that physicians who have individual contracts with such organizations as HMOs and PPOs are employees may not be as easy as Dr. Marcus would lead us to believe. The Michigan State Medical Society, stung

by an FTC ruling that its act as the "exclusive bargaining agent" for its physician members in negotiating for fees or reimbursement levels constituted restraint of trade, issued a warning in January this year to all its members about the dangers in joining a medical union. The society was referring mainly to potential violations of the antitrust laws.

The search for solutions to the problems that plague the medical profession, whether real or imaginary, simple or complex, will be a difficult job for physicians. Trade unions are just one of many alternatives. They have proven their clout in this country. But there are also pitfalls. Harnessing their strengths while avoiding the pitfalls will be a challenge to those who feel that trade unionism in medicine is an idea whose time has come.

R. G. Lacsamana, M.D.
Editor

A contract broken

The Florida Legislature passed a law in the waning days of the 1985 session which will exempt physicians of the Mayo Clinic from having to obtain a Florida medical license when they come to work in the Mayo facility being built in Jacksonville. The Mayo Clinic, as well as several other interests, had lobbied for this. The arguments seemed to be that these were eminent physicians employed by a prestigious medical center and their competency should not be open to question. It appeared to be a bother to have to restudy to pass the state boards or its equivalent. The pervasive feeling was that these academic physicians should make better use of their time than having to take exams to qualify for a Florida license. The other reason espoused, either implied or spoken, was that the Mayo Clinic in Jacksonville would provide millions of dollars for the community and nothing should be allowed to interfere with this.

Parts of both reasons are indisputable at first glance. Certainly, the Mayo Clinic is prestigious and renowned across the land. I do not know the magnitude of the Mayo Clinic in Jacksonville, but I think it would be safe to say that it will probably be worth millions for the Jacksonville economy. The Legislature apparently felt both of the reasons were sufficient to overturn the tradition of physician licensure which has existed in this state since the early 1900's. There have been individual exceptions over the years with visiting professors in medical schools, but nothing to compare with the mass exemption connected with the Mayo Clinic.

In passing the law the Legislature has ignored the history of licensure, the reasons for the evolution of professional regulation, and more important, has broken a contract with the people of Florida. To be sure, the majority of the citizens of this state have no idea a contract has been broken and if they did, would probably not raise a collective voice to speak out against it. They would equate it with a blow to organized medicine and may even applaud it, as apparently have many citizens of the Jacksonville area. However, a contract with them has been broken as surely as night follows day, and if they would study the issue it would send a shiver through their souls. Unfortunately, the physicians of this state are just starting to emerge from forty years of bad public relations and antagonism with many groups. For these reasons, we are probably the only ones who are going to speak out about this.

Let us examine the issues. The contract which has been broken is not only between the current citizens of Florida and the Legislature. It is between the government and the citizens of this country which has its roots in the establishment of a democratic system of political behavior. When people of the past began to consider ways to govern themselves, several concepts emerged from the political thought and philosophy which existed in the sixteenth and seventeenth centuries. What evolved was that citizens had to give up unrestricted freedom and live in a society which imposed restraints on individual behavior in return for the good of the whole. Also, the government accepted as its responsibility, and the people expected it, that the power of the central authority would be used to protect and to promote the welfare of its citizens. Out of this thinking would grow the regulatory process of any government. The regulatory process existed not only to regulate conditions for the good of the whole, but also for the protection of the individual.

From these thoughts and ideas would come the American Declaration of Independence and the Constitution of the United States. Both documents attempt to delineate the responsibilities of the individual and the government to each other. It is a tradition of American and English law that measures of public health are always within the authority of government. Here in the United States, this responsibility has largely been left to the states, but the federal government has stepped in when the need arose to use this regulatory power. In the early 1900's, amid a great public clamor for reform, the federal government moved with dispatch to regulate the food and drug industry for the good of the citizens. At that time, the Chicago stock yards shipped beef to the tables of America and were controlled by a few great packing companies, some of them unscrupulous. Tainted meat, contaminated with either rat droppings, dangerous chemicals, or

bacteria were being peddled to America, and the federal government, under the prodding of President Theodore Roosevelt, moved to stop this abuse of the health of Americans. In 1906, The Meat Inspection Act was passed which required that federal officials inspect all packing houses engaged in the interstate and foreign commerce and enforce sanitary regulations. The Pure Food and Drug Act also became law in that year which set standards for the production of food and manufactured drugs. Thus, in the early 1900's, the federal government laid standards for protection of the health and welfare of the citizens which have continued to this day.

The regulations of physicians at the state level were haphazard and lacking in criteria for both education and standards of competency in the early 1900's. Physicians were, in many cases, poorly trained in inadequate so-called medical schools or apprenticed to the practice of medicine with their individual quality obviously differing greatly. The medical profession led the struggle to establish educational standards and licensure requirements to insure the public safety. In 1910, the famous Flexner Report was issued which was a scathing indictment of the medical schools of the United States and Canada. As a result of this study, many medical schools closed and those which survived improved their curriculums. State licensing boards followed suit as standards for the issuance of a license to practice medicine were upgraded in the individual states. The action of the Florida Legislature broke that tradition. By granting special exception to the Mayo Clinic, the Legislature has abrogated its responsibility to the citizens of this state.

The argument that physicians at the Mayo Clinic are eminent and world renowned is inarguable. However, an entity, whether or not it is a medical clinic or an exalted office such as the Presidency of the United States, confers no special mantle of morality or high standards of conduct. Our system of laws recognizes this and each person is held accountable for his or her actions based on individual performances and not on a position held. This fact was recognized by the political thinkers of the past and checks and counter-balances were included in our system of government so a person in a position of importance would not impose his influence unduly. We have only to look to the Watergate episode to see that the office of the Presidency of the United States confers neither virtuous actions nor moral behavior. No, while the physicians of Mayo work in a clinic that is world-famous, the signing of a work agreement with that institution does not confer competency, righteous actions or moral conduct.

If economic aspects were overriding factors in the approval of license exception, then this is even more ominous. To break a contract between governed and government is sad in itself, but to be credited to sheer economics is frightening. I cannot cite specifics, but many say that interests backing the Mayo Clinic are heavily involved in legislative campaigns and other elections. While campaign contributions are a recognized part of our political process, this should weigh heavily on the conscience of those in which this took priority over an implied obligation which they accepted when they went to Tallahassee.

No, after all the reasons for the exemption of the Mayo physicians are examined in the light of the relations of the state and the citizens, it becomes even more apparent that the Florida Legislature, in this instance, failed to live up to its responsibility to protect the people of Florida through its regulatory powers. The reasons given for the dereliction of duty are flimsy and devoid of rational or worthy explanations.

H. Frank Farmer, M.D., Ph.D.
Historical Editor
New Smyrna Beach

The plague is spreading

Suddenly, physicians are not alone anymore. A flurry of headlines the past few weeks focused on the spreading tentacles of the liability problem and the dwindling number of insurance companies willing to provide coverage. Joining the company of doctors is an odd assortment of professionals and institutions including lawyers, architects, engineers, accountants, stockbrokers, real estate agents, insurance agents, directors of corporations, nurse-midwives, fishermen and fireworks makers, states, municipalities, and transit systems. All are now starting to feel the pinch of escalating premiums and the growing prospect of having no coverage at all. Although the possibility is far-fetched, *Forbes Magazine* in a recent article played up the bleak scenario where we may end up with a world without insurance.

The lesson to be learned from these developments is that the crisis can only deepen if we continue to ignore the problem. Over the past ten years, while phyicians were wrestling with a steadily worsening professional liability problem, a lot of people were laughing and even accusing the medical profession of trying to manufacture an artificial crisis. Few people are laughing anymore. More and more Americans now realize that we have a brutal tort system that encourages everybody to sue at the slightest perception of an imagined wrong or imperfection. Supreme Court Chief Justice Warren Burger, commenting on the litigious American

society, had implored lawyers on several occasions to seek other alternatives to the never-ending game of litigations.

We all feel that people who get injured by malpractice, incompetence, or negligence ought to be recompensed fairly. But what is happening reflects a system that has totally gone out of hand. The outlandish and outrageous multi-million dollar awards being handed out by juries clearly indicate the flaws in our tort system. When all is said and done, the only winners are the lawyers, some of whom become overnight millionaires by a perverted system of contingency fees that has no counterpart anywhere else in the civilized world.

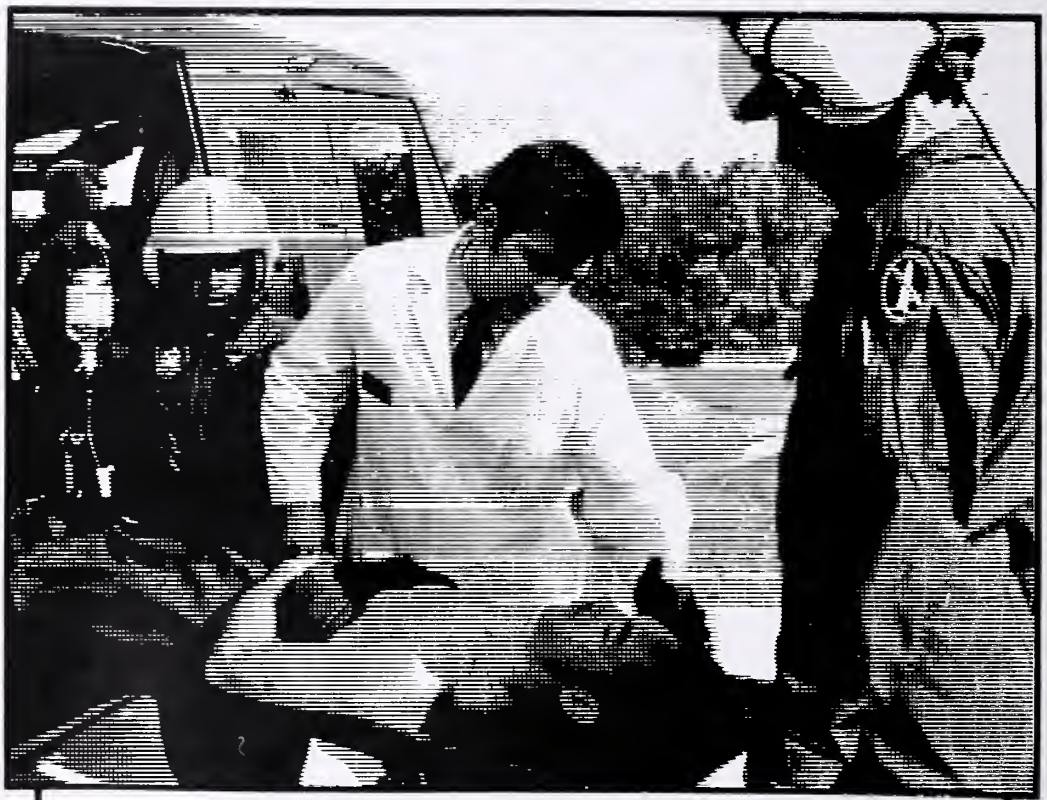
With things getting worse year by year, the suggestion that we may end up eventually with no available liability protection does not seem so far-fetched after all. Some of the biggest insurance companies have been hit by such staggering losses that they are withdrawing from the liability protection market. In addition, corporations such as Manville and A. H. Robins have filed for bankruptcies because of similar losses. Their actions may be a harbinger of things to come.

Nothing clearly dramatizes the evils of our system as the recent air tragedies in Japan and Dallas. A few days after the airplane crash near Tokyo, the president of Japan Air Lines resigned his post even though it was not his fault, while his company made settlements with relatives of the victims expeditiously without the aid of lawyers. In Dallas, even while aviation authorities were still poking through the ashes and debris for the unaccounted dead, newspaper reports told of lawyers hovering like vultures for the big feast ahead.

If it does nothing else, the present situation should at least stir our politicians and policy-makers to acknowledge that there is a critical problem, and perhaps prod them into seeking a far-reaching solution. Any proposed solution, whether it means taking malpractice and liability out of the tort system or passing a uniform liability law, should be fair and equitable. The public should support such action; after all, it should realize that those hefty millions being doled out here and there are coming out of its own pockets. The alternative is the present system that will continue to gouge us all.

R. G. Lacsamana, M.D.
Editor

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.


AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA...
SHE'S ABOUT TO GIVE UP ON ORAL-CONTRACEPTION.
NORLESTRIN®
(1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP) 1/50
BECAUSE SOMETIMES A 50 IS PREFERABLE.
See next page for brief summary of prescribing information

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows.

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives; however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision; onset of proptosis or diplopia, papilledema; or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives; however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy: Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.

2. Preexisting uterine leiomyomata may increase in size.

3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.

4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.

5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.

6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.

7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.

8. Serum folate levels may be depressed.

9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.

10. Certain endocrine and liver function tests and blood components may be affected. (a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; benign hepatomas; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma; breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin [21] 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [21] 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [Fe] 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [FE] 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [28] 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

0901G131

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

© 1985 Warner-Lambert Company

PD-21-JA-2563-P-1(11-84)

Legal and ethical implications of joint ventures

I remember being warned, even in medical school, about certain practices that were thought to be unethical. We were cautioned never to refer patients surreptitiously to a pharmacy in which we had a financial interest. In the state of near poverty in which I lived as a medical student, I could not imagine myself ever owning a pharmacy, or anything else worthwhile for that matter, but for some reason that particular ethical violation, although minor when compared to so many other ways in which physicians could exploit patients, has always stayed in my mind. I have always been careful to refuse free prescription pads from pharmacies which posted their name on the back of the blanks.

Chapter 458.331(1)(o) of the Florida Medical Practice Act lists as a ground for discipline: "Excercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or a third party which shall include, but not limited to, the promoting or selling of services, goods, appliances, or drugs, and the promoting or advertising on any prescription form of a community pharmacy unless the form also states, 'This prescription may be filled at any pharmacy of your choice.'"

The notion of possibly exploiting patients by referring them to a pharmacy in which the physician has a secret financial interest seems archaic, trivial and almost humorous when compared to contemporary arrangements in which physicians are involved in joint business ventures with hospitals, other physicians, and businessmen in the ownership and management of expensive biomedical equipment and health care facilities.

There are a large number of hospitals, in Florida and elsewhere, which are owned, in total or part, by practicing physicians who are also members of that hospital's medical staff. In some cases, stock shares in the hospital were granted to a physician contingent upon his continuing to admit patients, or perhaps even upon his promise to increase admissions and utilization of other hospital services. In some cases, profits promised to a physician-investor are not dependent on the amount of capital he has invested at all, but upon his ability to generate revenues for the hospital by utilizing the facility. Similar deals are being struck in the ownership of out-patient diagnostic centers, imaging centers, surgical centers, and a variety of other health care services. In most of these situations, certain types of physicians, such as dermatologists, allergists and psychiatrists, are often denied an opportunity to purchase shares because it is known that they are not likely to utilize the facility as much as internists or surgeons.

I have had some personal experience in these matters, having been rather closely involved with one hospital in Miami. I have served on many committees, including the executive committee, and I have been chairman of several. I would estimate that I have spent 1200 hours of uncompensated time serving this hospital over the past eleven years, and when the administration announced a joint venture in which physicians and the hospital would build and operate an out-patient diagnostic center, I signed a letter of intent to participate the very day the notice of inquiry reached my office. I have not been asked to purchase a share, however, even when some other physicians I know, who have not devoted any time on committees in service to the hospital, were offered a second share.

I sincerely believe that the hospital administration has nothing against me personally, but their decision to exclude me because of my specialty,

despite my eleven years of devotion, is typical to me of the crass commercialism that is so prevalent now in the health care field. If allowed to proceed unchecked, these practices may augur the destruction of the last remnants of decency and humanity in the medical profession.

I would like to describe some joint ventures that I have heard about, either from conversations with colleagues, from the business of the Board of Medical Examiners, or from having read of them in a variety of journals or newspapers. Decisions about their propriety may have a major impact on future business endeavors for physicians, on health care financing, and on the integrity and perhaps even the very existence of the medical profession.

Several internists and family physicians on the west coast of Florida were offered, for $1250.00, shares in a local pharmaceutical company which manufactures a generic equivalent of a well known cardiac drug. The company representative made it clear that if they wrote prescriptions for this generic brand, the company would profit and so would shareholders. They began to write for this particular generic brand every time they believed a patient needed this cardiac drug, and perhaps some even used the drug when not really even indicated. Several of the doctors even wrote "medically necessary," in their own handwriting, preventing the pharmacist from substituting other generic brands of the same drug, which may have been less expensive or perhaps even more effective. Have these physicians done anything wrong?

An orthopedic physician owned a half interest in a physical therapy practice with a licensed physical therapist, located several miles from his own office. If he had employed a physical therapist in his own office, patients could presume that he may benefit financially from a referral, but by separating the physical therapy office by several miles, patients could not know that the doctor owns an interest in that business. On many occasions, the orthopedist referred patients to this physical therapist, even though the patient lived in a different area of the county, and may have been better off seeing a physical therapist closer to home. Should the orthopedist be required to inform patients that he owns the physical therapy facility before referring them? Are these referrals improper?

An ophthamologist, who does medical and surgical ophthamology, employs an optometrist in his office who performs refractions. Patients are given prescriptions and are directed to a particular optical laboratory where they can have their eye glasses or contact lenses made. This laboratory is located about a half mile from the ophthamologist's office, and there is no way for patients to know that the ophthamologist owns the facility. The facility is not convenient to many patients, and prices are not a particular bargain, but still the ophthamologist directs most of his patients to this facility without informing them that he owns it. Is this practice improper? Should he inform patients that he owns the optical laboratory?

A physician sets up an office to perform echocardiograms and other special studies. He informs local cardiologists and internists that they can bill Medicare and other insurance companies directly for the special studies at prevailing rates, and he in turn will receive payment from them at a lower rate. In essence this contractual relationship produces a substantial fee to the referring physician for each patient sent for a special study. Does this arrangement constitute fee splitting? Is it illegal or unethical? Is this analagous to a physician charging more to a patient or insurance company for the interpretation of a pap smear than he must pay to the pathologist who actually is reading the slide?

A group of businessmen, including several physicians, builds an imaging center housing an expensive NMR unit. They have a lavish cocktail party at the poshest hotel in town and invite many local physicians and their wives, and make a brief presentation about their project. They explain the merits of NMR over CAT scans and conventional radiologic studies, and then suggest that each time a patient is referred for a study, the referring physician will acquire a single share of common stock in the NMR corporation, with a present par value of $25.00. A study is expected to cost $1200.00 at this facility, while a study at the only other NMR facility in town, which offers no equity interest to a referring physicians, costs $850.00. Does this contractual relationship represent illegal or unethical activity?

Shall the Board of Medical Examiners hold hearings and pass rules that instruct physicians about these matters, determining what business relationships are proper and legal, and which will be grounds for discipline by the board? What is your opinion on this subject?

Richard J. Feinstein, M.D.
Miami

Malpractice relief not on the way yet

The monumental efforts of the Florida and Illinois medical societies resulted in modest malpractice legislation. Both laws have similar, significant and ominous elements. The lawmakers insisted on more medical education and more licensing requirements, pointing the finger at medical incompetence and negligence as the cause of the crisis. They failed to mention that American

medicine was the best ten years ago. And after these years of extensive CME programs, the legal crisis only deepened.

Medical malpractice is not the cause of the crisis. There are a hundred thousand accidental deaths and several million major accidental injuries in this nation every year. Such incidents related to health care are negigible. Yet only the physician must carry a horrendous personal liability insurance. The new regulations also include some form of manipulation of the insurance industry. While the insurance companies' primary interest is their profit and survival, rearranging the insurance coverage has nothing to do with the problem. Even the righteous-sounding new arrangement of payment to injured parties and attorneys has nothing to do with the root of the crisis. It is my impression that the recently passed or planned legislation in such key states as Florida, Illinois, New York, California, etc. are mere cosmetic performances without substance. If I were a liability attorney, I would not lose sleep over the new statutes. They can be easily challenged in sympathetic courts. The success of such challenge is highly probable.

The failure of our defenses calls for complex explanation. There is only limited unity within the profession. The low-risk specialties and the medical societies in low risk states feel that they should not pay for the high risks of others. We even have a new emerging specialty of physicians who are willing to testify for any cause, at any time, on any side of any conflict for a fee. Our defenses lack the imagination and aggressiveness of the trial lawyers fighting for the liability millions. A major source of our failure is that we follow the traditional route which failed us in the past. We keep returning to the legislators who are dominated by the attorneys who have personal financial interests in the liability bounty. They have the clout to preserve the status quo and frustrate any meaningful reform.

We simply have to explore new avenues. The medical liability crisis has developed not because of an incompetent profession but because of the legal-judicial developments of the last three decades supported by liberal-activist courts. Example: the frivolous suits, aboiut two third of all suits, are very damaging to the physician professionally, economically and emotionally. They are also extremely profitable for the attorneys. The insurance companies rather pay than fight in court. It is "the economical" solution. The frivolous suit is legally possible and judicially sanctioned for profit. It is unthinkable in any civilized country, and in my humble opinion, constitutionally untenable. It is time for the present more conservative U.S. Supreme Court to review this and similar practices which make up the backbone of the crisis.

Medicine used to be a biological-social science. We still teach it and practice it as such. But medical diagnosis and therapy became legal acts. We are held accountable for practices which we never heard about in school or were never so stated by statute. If we practice a legal act, that standard should be defined in legal terms by the licensing authority: what tests to run, what therapeutic course to follow. Traditional medicine gave us ample freedom of choice. Today's "legalized" medicine is unyielding. The government which enforces liability should have the responsibility to define accountability by law before the fact and before the enforcement, if I read the Constitution properly.

Is malpractice relief coming (Editorial J. Florida MA July 1985)? Currently, I see no such sign. We must do better.

James Scott, M.D.
Streator, Illinois

Federal liability law needed

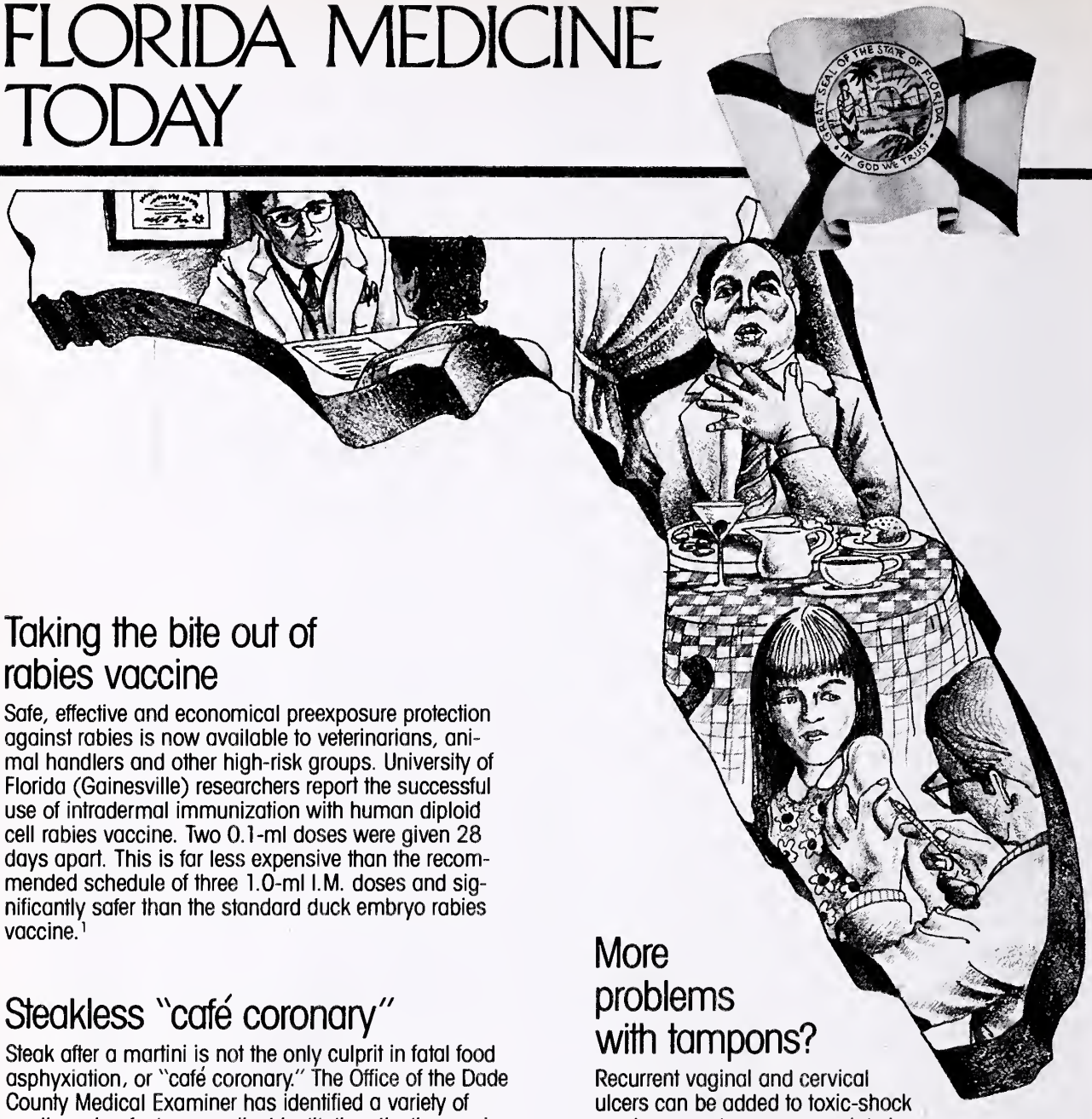
The problem of liability claims and insurance coverage is now affecting all segments of our society, not just hospitals and the medical profession. The municipalities, the pharmaceutical industry, aircraft industry, airlines, architects, engineers, CPA's, and the automotive industry are being devastated by multi-million dollar liability judgements and soaring insurance premiums. Several large municipalities are considering discontinuing their liability insurance as they cannot afford it.

In every crisis, there is an opportunity for change. If the above groups could form a task force and, along with the insurance industry, approach the problem on a federal level, there would be a chance for change. This task force would be a very powerful political bloc which would get the attention of senators and congressmen. What is needed is a uniform federal liability law addressing the current differences in various state laws, pain and suffering, and contingency fees. Any of the above groups going alone would have a very difficult time and probably fail, but together, the fight could be won.

William W. Schildecker, M.D.
Daytona Beach

Roche salutes

FLORIDA MEDICINE TODAY



Taking the bite out of rabies vaccine

Safe, effective and economical preexposure protection against rabies is now available to veterinarians, animal handlers and other high-risk groups. University of Florida (Gainesville) researchers report the successful use of intradermal immunization with human diploid cell rabies vaccine. Two 0.1-ml doses were given 28 days apart. This is far less expensive than the recommended schedule of three 1.0-ml I.M. doses and significantly safer than the standard duck embryo rabies vaccine.[1]

Steakless "café coronary"

Steak after a martini is not the only culprit in fatal food asphyxiation, or "café coronary." The Office of the Dade County Medical Examiner has identified a variety of predisposing factors: medical institutionalization, sedative drugs, parkinsonism, old age, poor dentition and alcohol consumption. With institutionalized adults, friable foods not amenable to the usual rescue techniques are often involved. Observers were present in a full 85% of fatal cases, indicating a need for increased public awareness. Instruments for retraction of foreign bodies should be made readily available at public facilites and nursing homes. And new techniques should be developed to deal with soft foods that cannot be cleared by a grasping device or the Heimlich maneuver.[2]

More problems with tampons?

Recurrent vaginal and cervical ulcers can be added to toxic-shock syndrome as tampon-associated ailments. A report from South Miami Hospital indicates they may occur in one-fifth of menstruating women and are more common with long-term use. Moreover, microulceration has been reported within one hour after tampon insertion. Symptoms may also be subtle and often the same as those for which tampons are used, including spotting and discharge. Dyspareunia, urinary frequency and urgency and dysuria may also be present. Care must be taken to avoid undue delay in the diagnosis and to rule out carcinoma.[3]

Copyright © 1985 by Roche Products Inc. All rights reserved.

References: 1. Burridge MJ *et al: JAMA 248*:1611-1614, Oct 1, 1982
2. Mittleman RE, Wetli CV: *JAMA 247*:1285-1288, Mar 5, 1982.
3. Weissberg SM, Dodson MG: *JAMA 250*:1430-1431, Sep 16, 1983.

ROCHE®

TODAY: FOR THE PATIENT WITH MIXED DEPRESSION AND ANXIETY

A rational approach, combining
- The standard antidepressant: amitriptyline
- The proven anxiolytic action of Librium® (chlordiazepoxide HCl/Roche) Ⓘⓥ

Marked improvement often occurs as early as the first week

Headache, insomnia or GI upsets associated with mixed depression and anxiety often respond quickly

Feeling better, patients feel encouraged to stay the course—therefore, fewer dropouts: $P = .006$ compared to amitriptyline*

Convenient single *h.s.* dosing sufficient in some patients; helps patients with mixed depression and anxiety sleep through the night. Patients should be cautioned about the combined effects of Limbitrol with alcohol and other CNS depressants, and about activities requiring complete mental alertness such as operating machinery or driving a car.

In moderate depression and anxiety

IN PLACE OF LIMBITROL 5-12.5 WRITE: **Limbitrol®**

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

IN PLACE OF LIMBITROL 10-25 WRITE: **Limbitrol® DS**

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Easier to remember... easier to prescribe

*Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Please see summary of product information on following page.

LIMBITROL® Ⓥ Tranquilizer-Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

ROCHE®
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
September 1985, Vol. 72, No. 9

Thin needle aspiration biopsy as diagnostic tool: community hospital experience

Jorge G. Arroyo, M.D. and Frank M. Taylor III, M.D.

ABSTRACT: Thin needle aspiration cytology is a technique which, when used advisably, provides an accurate and economical mode of diagnosis. Our experience encompasses multiple anatomic sites (breast, lung, liver, thyroid, pancreas, lymph node and subcutaneous tissues) and spans a period of four years. Of 750 cases, 593 have been followed-up with surgical biopsy and/or six months of clinical documentation. Among these cases, we report no false-positives, and an 8.8% false-negative rate. A key to accurate diagnosis is meticulous collection and preparation of material, which is assured by close pathologist interaction at the time of the procedure.

The Authors
JORGE G. ARROYO, M.D.
FRANK M. TAYLOR III, M.D.
Dr. Arroyo and Dr. Taylor are both Clinical Assistant Professors of Pathology at the University of South Florida College of Medicine and St. Joseph's Hospital, Tampa.

Diagnosis via thin needle aspiration cytology dates to the 19th century when Leyden[1] in 1883 successfuly described the cytologic components of bronchopneumonia. While much of the development of cytologic diagnosis awaited Papanicolaou's definitive work in the 1940s, thin needle aspiration cytodiagnosis was pioneered and fostered as a legitimate diagnostic tool for the two preceding decades at the Karolinska Institute in Sweden and Memorial Hospital Center in New York.[2]

In Europe, the method flourished and gained wide usage among internists and hematologists. In the United States, however, early popularity waned in the wake of publications emphasizing the physical limitations of the procedure and warning against the possible seeding of tumor cells.[3]

More recently, scientific and medical economic developments within the United States have caused a new surge of interest in the technique. Indeed, our experiences with thin needle aspiration biopsy prove it to be a valuable diagnostic tool. When compared with the open biopsy that it sometimes is able to replace, the differences in morbidity, complication rates, and cost to the patient are significant.[4]

Materials and methods • During the past 48 months, we have examined over 750 thin needle aspiration biopsies which have been performed in our hospital or referred to us by private physicians. In this study we have included cases in which tissue diagnosis was subsequently obtained and cases in which there is more than six months clinical follow-up if surgical confirmation was not possible.

All in-hospital aspirations required similar material and followed a common routine. When necessary, ultrasonography, biplane fluoroscopy,

and/or CAT scan guidance were provided by radiologists for precise placement of the needle into the suspected lesion. Some cases required only palpation and manual fixation of the mass.

Necessary equipment included a narrow caliber needle, preferably 22 gauge, ranging in length from 3 to 20 cm. Chiba University needles were used almost exclusively for lung and deep organ biopsies. Additional material included 20 ml plastic syringes, Cameco syringe holders, Coplan jars with 95% alcohol, and 10 ml containers with 50% alcohol. Culture media and special fixatives for electron microscopy were made available when clinically indicated.

In all procedures carried out in the hospital, the actual aspiration and preparation of slides were performed or immediately overseen by a pathologist. Once obtained, the smears were promptly fixed in 95% alcohol and stained via Papanicolaou rapid staining technique or hematoxylin and eosin. A fraction of the aspirate was routinely maintained in 50% ethyl alcohol for later cytospin and/or cell block preparation. Following examination of initial smears, the pathologist made a pronouncement as to adequacy of the specimen and, when possible, rendered a provisional diagnosis. This procedure allowed for immediate resampling when the first aspirate was found to be inadequate for diagnosis. A final report was issued after all the slides, special procedures, and stains became available.

Specimens received by way of the outpatient laboratory had been prepared in the offices of subscribing physicians and arrived prefixed in 95% ethyl alcohol. From that point, specimens were treated in a manner similar to that utilized for hospital patients. All smears were reported as "positive," "suspicious," "negative for malignancy," or "unsatisfactory."

Results • A total of 593 cases were selected for this study. The distribution of cases is shown in Table 1. Of these, 259 were negative for malignancy, while 225 were positive for malignancy. Of the remainder, 45 were designated as suspicious for malignancy and 64 were deemed unsatisfactory for diagnosis.

After surgical and/or thorough clinical follow-up, no false-positives were found among any of the malignant cytologic diagnoses in our series. Of the 45 "suspicious" cases, 35 were later found to be malignant. Among the 259 "benign" designations, 21 were later reported as having had malignancies. Considering the "benign" and "malignant" categories only, our sensitivity for detecting malignancy was 91%, while our specificity was 100% (Table 2).

Breast, lung, liver, and thyroid were the sites most frequently examined in our series. Among our group of breast aspirates, every positive or suspicious case was subsequently biopsied. In addition, several cases reported to be benign were biopsied. Of the 28 cases reported as suspicious, 22 were found to be malignant on biopsy. Among the 154 cases reported as benign, eight were subsequently found to be malignant on biopsy. A total of 56 of the 303 breast aspirates were not satisfactory for diagnosis. The vast majority of these were specimens received from physicians offices (Table 3).

Table 1. — TNAB.

Breast	302
Lung	121
Thyroid	52
Lymph Node	35
Liver	27
Pancreas	10
Bone	12
Salivary Gland	8
Soft Tissue	6
Skin	6
Kidney	6
Eye	3
Scalp	2
Adrenal	2
Orbit	1
	593

Our experience with lung aspirates paralleled that with the breast. In all cases, our diagnosis of malignancy was confirmed either surgically or clinically. Of the seven cases reported as suspicious, five were subsequently proven to be malignant. Of 26 reported benign aspirates, nine were later proven to be malignant (Table 4).

Liver aspirations yielded no false-positives or false-negatives. One case reported as suspicious on thin needle aspiration was subsequently found on open biopsy to be malignant (Table 5).

Similar is our experience with needle aspirations of the pancreas. Two benign as well as six malignant diagnoses were later confirmed. Two cases called suspicious proved to be well differentiated adenocarcinomas at surgery.

Table 2. — Thin Needle Aspiration Biopsies, All Sites.

		Benign	Malignant
Benign	259	238	21
Suspicious	45	10	35
Malignant	225		225
Unsatisfactory	64		
Total	593	248	281

Sensitivity 91%
Specificity 100%

Table 3. — Thin Needle Aspiration Biopsies of Breast Lesions.

		Benign	Malignant
Benign	154	146	8
Suspicious	28	6	22
Malignant	64		64
Unsatisfactory	56		
Total	302	152	94

Table 5. — Thin Needle Aspiration Biopsies of Liver Lesions.

		Benign	Malignant
Benign	11	11	
Suspicious	1		
Malignant	13		13
Unsatisfactory	2		
Total	27	11	14

Fifty-two thin needle aspiration biopsies of the thyroid gland were performed. Of the 42 cases reported as benign, only one was subsequently found on surgical exploration to harbor a carcinoma. Of the two aspirations reported as suspicious, one was later shown to be malignant. All three aspirations reported as malignant were confirmed via surgery to be neoplastic (Table 6).

Thirty-five lymph nodes were sampled and our 15 benign and 18 malignant diagnoses were confirmed. We were unable to make a definite diagnosis of malignancy in two cases of small cell lymphomas. They were reported as suspicious in the aspiration biopsy.

Discussion • A review of the 593 needle aspiration cases reveals a number of salient features. Of foremost importance to our department was the complete absence of false-positive reports among the outright diagnoses of malignancy. This compares favorably with the small but nevertheless meaningful 1% false-positive rate reported in most series.[5-11] Conversely, of the 230 cases reported as benign, further investigation yielded 21 malignant diagnoses, or an 8.8% false-negative rate. An additional important result of this study has been appreciation for the pathologist's involvement in the actual performance of the aspiration procedure. Although this has been shown to be time-consuming and on some occasions not absolutely necessary, in most instances the oportunity to become acquainted with the clinical facts and to discuss the radiologic findings where available has been of great assistance in reaching a specific diagnosis. This is contrasted with the relatively high incidence of cytologies classified as suspicious or unsatisfactory which are received from outside sources without benefit of on-site pathologist interaction.

The various aspiration sites have yielded specific insights peculiar to the particular technique involved and anatomic location. Regarding thin needle aspiration biopsies of the breast, it is our experience and that of the literature in general[9-12] that a cytology positive for malignancy is useful to the clinician and patient in a number of unique ways. For one, it allows the clinician to inform the patient of his or her disease. Knowing this, the necessary one-stage surgical procedure can be scheduled, preceded by the indicated staging and consultation methodologies. As mentioned previously, several reports in the literature indicate cases of false-positives by large, very experienced groups. Because of our limited number of cases and the usual lack of clinical information in breast specimens, we advise the surgeon to confirm our cytologic diagnosis by frozen section before the mastectomy is carried out, simultaneously securing an adequate sample of tumor for receptor assays.

Intrathoracic lesions were routinely aspirated under the able guidance of the radiologists. With the aid of biplane fluoroscopy or CAT scan, the radiolo-

Table 4. — Thin Needle Aspiration Biopsies of Lung Lesions.

		Benign	Malignant
Benign	26	17	9
Suspicious	7	2	5
Malignant	87		87
Unsatisfactory	1		
Total	121	19	101

Table 6. — Thin Needle Aspiration Biopsies of Thyroid Lesions.

		Benign	Malignant
Benign	42	41	1
Suspicious	2	1	1
Malignant	3		3
Unsatisfactory	5		
Total	52	42	5

gist would place the needle (preferably a 22 gauge Chiba) into the suspicious area. The pathologist then obtained the aspirate and prepared the slides immediately, examining for adequacy. In the case of inaccurate localization and/or inadequate sampling, immediate repeat of the procedure could be performed conveniently until a satisfactory specimen had been harvested. In our sampling of 120 lung lesions, only one specimen was judged unsatisfactory, that patient having developed a complete pnuemothorax on the first puncture and thereby requiring immediate placement of a chest tube. This, incidentally, was our only serious complication.

In addition to the Chiba needle, the Wang needle has also been helpful. This was particularly indicated in attempting to aspirate submucosal and parabronchial lesions visualized via the fiberoptic bronchoscope.

Even though our desire was to properly categorize lesions according to cell type, a number of pragmatic considerations supervened in dealing with thoracic lesions. The first, and most obvious, was distinguishing between benign and malignant. If malignant, however, our primary concern was in separating small cell anaplastic carcinoma from the remainder of bronchogenic malignancies.

The liver was the intraabdominal site most frequently sampled. Owing to the small diameter of the Chiba needle, a large area of the liver could be sampled with negligible risk to the patient. Based on our experience, it is our contention that thin needle aspiration biopsy is more sensitive, especially in diagnosing metastatic tumors, and far less dangerous than the conventional "core" needle biopsy using wider caliber needles such as the Vim-Silverman.[13]

Particularly rewarding has been our experience in pancreatic aspiration biopsies. Using CAT scan to insure correct placement, we have been able to diagnose six cases of pancreatic carcinoma.

Thin needle aspiration biopsy of the thyroid has also proven itself to be a useful diagnostic aid and clinicians are becoming more confident in it. It has saved some patients the necessity of surgery when the clinical diagnosis of benign colloid goiter was supported cytologically.

Enlarged superficial lymph nodes were usually an easy target and did not require radiologic assistance for localization. Diagnosis was usually simple and clear-cut in cases of metastatic tumor, cases of lymphoma proving to be more of a diagnostic challenge. Thin needle aspirations have shown themselves to be particularly helpful in obtaining samples for fungal and bacterial culture prior to the institution of definitive antibiotic therapy.

Conclusion • From our results, we believe that thin needle aspiration biopsy has proven to be a valuable diagnostic tool. Its overwhelming potentiality lies in diagnosing malignancies. In this context, there must be adequate sampling and proper handling of the specimens. Pathologist involvement in the obtaining and preparing of specimens assures a maximum of cytologic detail. An abundance of clinical correlative information and/or surgical biopsy confirmation, where clinically feasible, provide a safeguard against a low but widely reported false-positive rate. Finally, thin needle aspiration can provide, when used advisably, an economical approach to work-up of patients. Its usage can allow for diagnosis in the outpatient setting, more convenient planning of treatment modality, and a potential decrease in complications from invasive procedures.

References

1. Leyden, H.: Ueber Infections Pneumonie, Deutsche Mediziniske Wochenschrift 9:52-54, 1883.
2. Martin, H.E. and Ellis, E.S.: Biopsy by Needle Puncture and Aspiration, Ann. Surg. 92:169-182, 1930.
3. Ochsner, A. and Debakey, M.: Significance of Metastasis in Primary Carcinoma of Lungs, J. Thorac. Surg. 11:357-387, 1942.
4. Kaminsky, D.B.: Aspiration Biopsy for Community Hospital, Chapter 7, Masson Monographs in Diagnostic Cytopathology, 1981.
5. Dahlgren, S.E.: Aspiration Biopsy in Intrathoracic Tumors, Acta Path. Microbiol. Scand. 70:566-567, 1967
6. Sinner, W.: Transthoracic Needle Biopsy of Small Peripheral Malignant Lung Lesions, Invest. Radiol. 8:305-314, 1973.
7. Sinner, W.: Pulmonary Neoplasms Diagnosed with Transthoracic Needle Biopsy, Cancer 43:1533-1540, 1979.
8. Todd, T.; Weisbrod, G.; Tao, L., et al: Aspiration Needle Biopsy of Thoracic Lesions, Ann. Thor. Sur. 32:154-161, 1981.
9. Johnson, R.D.; Gobien, R.P., and Valicenti, J.F.: Current Status of Radiologically Directed Pulmonary Thin Needle Aspiration Biopsy, Ann. Clin. Lab. Science 13:225-239, 1983.
10. Frable, W.J. and Frable, M.A.: Thin Needle Aspiration Biopsy, Cancer 43:1541-1548, 1979.
11. Stabric, G.D.; Tevcec, D.T., et al.: Aspiration Biopsy Cytologic Method in Diagnosis of Breast Lesions, Acta. Cytol. 17:188-189, 1973.
12. Rosen, P.; Hajdu, S.; Robbins, G., et al.: Diagnosis of Carcinoma of Breast by Aspiration Biopsy, Surg. Gyn. Obstet. 134:837-839, 1972.
13. Ho, C.S.; McLoughlin, M.J., et al.: Guided Percutaneous Fine Needle Aspiration Biopsy of Liver, Cancer 47:1781-1785, 1981.

• Dr. Jorge G. Arroyo, St. Joseph's Hospital, 3001 West Buffalo Avenue, Tampa 33607.

Toxic environmental substances and concerns of their effects on public health

John E. Davies, M.D., M.P.H., and Carl D. Pfaffenberger, Ph.D.

ABSTRACT: An eight-step plan is suggested for implementing a concerted effort to investigate a pollution situation as soon as its potential source becomes identified.

The Authors
JOHN E. DAVIES, M.D., M.P.H.
CARL D. PFAFFENBERGER, Ph.D.
Dr. Davies is Professor and Chairman of the Department of Epidemiology and Public Health and Dr. Pfaffenberger is Professor and Chief of the Division of Chemical Epidemiology, University of Miami School of Medicine, Miami.

There are at least three reasons why it is important that we have a concerted plan of action when potentially health threatening pollution situations become identified. The first is ecological, for Florida is particularly vulnerable to environmental perturbations, and the very nature of the water supply places the general population at risk to health insults. The population is rapidly expanding, resulting in phenomenal growth in land development and building construction while placing new demands upon basic water systems. Moreover, the physical and geological characteristics of the terrain with clusters of highly industrialized populations in close proximity to broad agricultural areas and new industrial complexes enhance the potential for both surface and groundwater contamination via run-off of agricultural pesticides and fertilizers, seepage from unmanaged toxic waste dumpsites, and various industrial effluents.

The coral matrix of the Biscayne, Floridan and other acquifers is particularly susceptible to chemical seepage and groundwater contamination as a result of its somewhat unique geophysical characteristics, and Lake Okeechobee, the major source of surface water for the southern part of the state, is bordered by agricultural areas whose productivity is highly dependent on pesticide and fertilizer use. In northern Florida, the potential for contamination of the St. Johns River from groups of industrial complexes also renders this important source of surface water highly susceptible to contamination. Apart from water supply, the semitropical climate and the potential it affords to year-round agricultural programs (as well as pest and mosquito prevalence) necessitates extensive use of chemicals for both food production and control of vector-borne diseases.

Secondly, the potential health impacts chemical pollutants have on public health and family practitioners are gaining greater attention. Both components of this health team are being confronted with health related problems and concerns related to pollution; yet there is practically no coordinated approach to diagnosis, management or research by the primary and/or the community health practitioner.

A third reason these concerns are timely is the general public and individual patient interest currently stemming from the numerous episodes of environmental contamination which have appeared in the public media over the past few years. At the national level, events such as Love Canal and Times Beach and the gradual recognition of many unmanaged hazardous waste dumpsites have increased general concern for human and environmental protection against the ravages of toxic and environmentally destructive chemicals.

Response to pollution • In Florida, several toxic waste dumpsites have received Superfund priorities. Similarly, at the state level, public concern has stemmed from reports of contaminated food and water supplies by Temik (aldicarb) and EDB (ethylene dibromide; 1,2-dibromoethylene) and the contamination of raw and finished drinking water with trihalomethanes and other chlorinated solvents, especially trichloroethylene and tetrachloroethylene as well as gasoline from leaking underground storage tanks.

From a public health perspective the recognition of potential "hotspots" of pollution and the associated potential population at risk necessitates a very specific and organized response. Past experiences in such areas as Love Canal have emphasized the importance of public information during all stages of any investigation. A contamination incidence calls for the identification of the who, the what, the where and the how as well as the subsequent steps of cleanup, disposal, prevention of recurrence and necessary health surveillance. Ideally the following steps should be implemented when a potential source of pollution is recognized:

1. Identification and delineation of the source of pollution and the chemicals involved, their toxicities, and their potential for movement through the environment via food chains and/or surface or groundwaters.
2. Immediate institution of appropriate human and environmental monitoring programs to effectively assess exposure and identify high risk subgroups within the area.
3. Collaboration with appropriate state agencies to assure that appropriate cleanup and disposal of the contamination is set in motion.
4. Institution of appropriate measures of monitoring and protecting workers involved in the cleanup procedures.
5. Dissemination of the appropriate public information.
6. Conduction of appropriate epidemiologic studies (when necessary) to determine the extent of the health effects and the relative risks resulting from the environmental exposure as well as the disease end-points of concern.
7. Enforcement of regulatory steps to prevent recurrence of similar contamination situations.
8. Continuation of postexposure monitoring and epidemiologic studies well past the initial date(s) of exposure.

Epidemiologic studies • The primary objective of epidemiologic studies is to define the relationship between environmental exposure and disease effects and to determine whether or not the exposure-effect is causal. Such a process will always be an indirect assessment of etiology, which means that very precise measurements of exposure must be related to equally precise expressions of disease. The association of environmental exposure with any specific disease end-point calls for well designed analytical studies. Causality will be suggested when: (a) a dose-response relationship is demonstrated, (b) the suspect exposure precedes the suspect illness, (c) the strength of the association is strong and is subsequently demonstrated in similar and later studies in other parts of the world, and (d) the observed effect falls within the bounds of biologic plausability. Limitation of epidemiologic studies will occur when the sample size of the population under study is insufficient to demonstrate a health effect with a given degree of power. This is dependent upon the magnitude of exposure and the frequency expected relative to the disease being studied. Rare diseases require very large study populations. Another limitation is based upon the latency period of a disease under study. This is especially the case in measuring risks of cancer where a 10-30 year induction period requires the use of sizable prospective studies or the utilization of retrospective studies where the exposure has already occurred and thus introduces inherent risk of recall bias. A final limitation of such studies relates to the clinical nonspecificity of the response.

To assess the health effects which may (or may not) have resulted from exposure to environmental chemicals, the family physician must take great care to ascertain the individual's exposure history. This calls for a detailed analysis of the nature of the work in which the patient has been involved, whether acute or chronic (or both) exposure has occurred, and what compounds were involved and when. The

clinical manifestations being presented by the patient, if related to the exposure, should conform to the known toxicities of the compound(s) to which the patient has been exposed. Sometimes exposure may be verified by appropriate urinary, fat or other tissue residue studies. Under such circumstances the body burdens of the suspect chemicals can be quantified. It is thus apparent that the investigative steps conducted by both the public health physician and the family doctor follow the same investigative channels, and the ultimate resolution as to the relationship of exposure and suspected health effects will require a combination of clinical acumen and epidemiologic skills of both types of health care deliverers.

- Dr. Davies, Epidemiology and Public Health, University of Miami School of Medicine, 1550 Northwest 10th Avenue, Suite 100, Miami 33136.

Risk factors for tumor recurrence after radical hysterectomy for stage IB squamous cancer of cervix

Robert C. Nuss, M.D., Guy Benrubi, M.D., and William Hazlett, Ph.D.

ABSTRACT: Seventy-six patients with stage IB squamous cell cancer of the cervix were analyzed for histopathologic risk factors for recurrence. Disease recurred in 12 patients. Age, race, tumor grade, tumor type, vascular space involvement, peripheral or stromal eosinophilia and positive mucin stain were not found to be significant risk factors. Tumor size (p = .0107), depth of stromal invasion (p = .0006), remaining disease free stroma (p = .0231) and nodal involvement (p = .0436) were significant prognostic variables. Stepwise discriminate analysis revealed depth of stromal invasion as the most important risk factor.

The Authors
ROBERT C. NUSS, M.D.
GUY BENRUBI, M.D.
WILLIAM HAZLETT, Ph.D.
Dr. Nuss is Director of the Division of Gynecologic Oncology, Dr. Benrubi is Assistant Professor of the Division of Gynecologic Oncology, University Hospital of Jacksonville, and Dr. Hazlett is with the Department of Statistics at the University of North Florida, Jacksonville.

Radical hysterectomy is an accepted treatment for stage IB squamous cell cancer of the cervix. Five-year disease free rates have been reported to be about 85%.[1-22] Several investigators have attempted to identify risk factors for increased recurrence after surgery and thus determine who would benefit from adjuvant radiation therapy. These factors have included age,[18] cell type,[23] tumor grade,[1] nodal metastases,[9] peripheral and stromal eosinophilia,[7] vascular space involvement[4] and depth of stromal invasion.[1,10,16]

This report is an attempt to clarify the role of these variables as prognostic indicators in stage IB squamous cell cancer of the cervix.

Materials and methods • From September 1973 to December 1981, 129 patients underwent radical hysterectomy , performed by our surgeon, at University Hospital of Jacksonville, Florida, and seventy-six of these patients were studied. Those included in the study were clinically in stage IB and had pure squamous cancer. Those patients with stage IIA, adenosquamous histology or primary endometrial cancers were excluded. Two-year follow up was obtained on all 76 patients. The procedure performed was a Clark-Wertheim radical hysterectomy with pelvic lymphadenectomy and paraaortic lymph node sampling. The average number of nodes excised was 35. Pathology specimens were reviewed with respect to factors previously outlined. Depth of stromal invasion was measured from the basement membrane. Depth of remaining tumor-free stroma was also measured. Charts were reviewed to identify those patients who had received radiation therapy and the reason for such therapy. Sites of recurrence were noted. In 35 cases, the specimen was stained with mucin stain. Though all these tumors had been

read as "pure" squamous, an attempt was made to determine if a positive mucin stain was an indication of increased recurrence risk. Statistical tests used were Fisher's exact test, chi-square test and stepwise discriminate analysis.

Results • Sixty-four (84%) of 76 patients remained disease free; 12 (16%) had recurrence. Mean age for the disease-free group was 40.03 ± 11.31, and for the recurrence group 39.66 ± 13.78. Fifty-two (68.4%) patients were white, 23 (30.3%) black, and one (1.3%) oriental. In the recurrence group, eight (67%) were white and four (33%) black.

In the whole group, seven (9.2%) patients had grade I disease, 37 (48.7%) grade II, and 32 (42.1%) had grade III. Among those with recurrence, five (41.6%) had grade II, and seven (58.3%) grade III. Forty-seven (61.8%) had large cell nonkeratinizing tumor, 27 (35.5%) large cell keratinizing and two (2.6%) small cell. In the recurrence patients, eight (66.7%) had large cell nonkeratinizing, three (25%) large cell keratinizing and one (8.3%) small cell tumors.

Twelve (15.8%) of the 76 patients had metastases to pelvic nodes. Five (41.7%) of these patients had recurrence. Of the 64 patients with no nodal involvement, seven (10.9%) had recurrence.

No patients in the study had involvement of the margins of resection with tumor.

Eleven patients received adjuvant radiation therapy, ten of the 12 with positive nodes and one for deep stromal invasion. Of the ten patients with positive pelvic nodes who were radiated, three (30%) had recurrence.

Fifteen (18.4%) of the pathologic specimens were found to have vascular space involvement. Of these, two (13.3%) were from patients who later developed recurrent disease. Ten (16.3%) patients of the 61 with no vascular space involvement had recurrence.

Twelve (15.7%) patients had peripheral eosinophilia and three (25%) of these had recurrence, as compared to nine (14%) recurrences in the 61 patients with no eosinophilia. Fourteen (18.4%) exhibited stromal eosinophilia, and three (21.4%) had recurrence. Nine (14.5%) of 62 patients without stromal eosinophilia developed recurrent disease.

We were able to perform a mucin test on 35 specimens. Eleven (31.4%) were positive. Three (27.3%) of these had recurrence, compared to three (12.5%) recurrences in the 24 mucin negative patients.

Twenty-one (27.3%) patients had tumors greater than or equal to 4 cm in size. Eight (38.1%) recurred. There were four (7.3%) recurrences in the 55 patients whose tumors were less than 4 cm in diameter. There were no recurrences in patients with tumors less than 3 cm.

Twenty-eight (36.7%) had stromal invasion greater than 10 mm. Nine (32.2%) recurred. Three (6.3%) of the 48 patients with 10 mm or less stromal invasion had recurrences.

Statistical analysis by tests listed under materials and methods revealed that in this group of 76 patients, age, race, tumor grade, tumor type, vascular space involvement, peripheral or stromal eosinophilia, and positive mucin stain were not significant risk factors for recurrence.

Tumor size ($p = .0107$), depth of stromal invasion ($p = .0006$), remaining disease-free stroma ($p = .0231$), and nodal involvement ($p = .0436$) were significant prognostic variables. Stepwise discriminate analysis revealed that nodal status depended on depth of stromal invasion ($p = .0001$) and that depth of stromal invasion was the most important variable.

Discussion • Age, tumor grade and type, vascular space involvement, and both kinds of eosinophilia have been found to have varying importance as prognosticators of recurrence. Reports in the literature are in disagreement as to their significance. Definitive answers will have to wait publication of ongoing cooperative studies.

Mucin stain of what appears to be otherwise "pure" squamous lesions has not been extensively examined. Adenosquamous tumors tend to behave more aggressively. Therefore the question arises whether or not positively staining squamous tumors will be "bad actors." In the small group of patients within the larger series of this report, this was not the case. Larger studies may lead to different conclusions.

In recent reports the importance of depth of stromal invasion has been elucidated. What still needs to be defined is the role of adjuvant therapy under specific risk criteria. In endometrial malignancy it has been shown that depth of myometrial invasion is the most important single factor for recurrence even if pelvic and paraaortic nodes are free of metastases. Adjuvant radiation in such cases of endometrial cancer is an accepted treatment.

In cervical disease Gauthier et al[10] in a series of 100 patients with squamous cell cancer confirmed that depth of stromal invasion was the most important variable, and were then able to identify low, intermediate, and high risk groups for recurrence based on depth of stromal invasion and lesion size. In the low risk group five year survival was 97% while in the high risk group it was 31%.

In 1980, Albrehayaghu[1] et al in a series of 35 patients identified six who had outer 1/3 stromal invasion, grade III histology, and no nodal metastases. Three of these patients were radiated postradical hysterectomy and were subsequently free of disease.

Of the three that received no adjuvant therapy two had recurrence.

In our series, of the 12 recurrences in 76 cases, seven occurred in patients who had no nodal metastases and no involvement of specimen margins with cancer. None of these patients were radiated. Six of the seven had local recurrences. If Gauthier's criteria were used on these patients, five would have been in the high risk group and two in the intermediate risk group. The unanswerable question is whether the recurrence rate in the group of seven patients would have been significantly lowered if any or all of them had been radiated.

A large cooperative study is needed to clearly define the role, if any, of adjuvant therapy in patients with certain histologic risk factors. Part of the answers may emerge from the recently completed surgical-pathological study of the Gynecologic Oncology Group. However, a more detailed study may be needed. All specimens would need to be sectioned in such a way that depth of stromal invasion as well as percent of stromal penetration could be accurately measured. Using a multifactorial analysis the risk of recurrence at certain depths of invasion, when other histologic criteria are present or absent, could then be determined. For example, in our study such analysis showed that at 11.5 mm invasion there was a 25% chance of recurrence, and at 17.9 mm the risk was 50%. However, the series was too small for 95% confidence limit. Once the relative risks are determined in a cooperative study, then randomization can be carried out, and hopefully the role of adjuvant therapy defined.

References

1. Abdulhaydglu, G.; Rich, W.; Reynolds, J. and Disaia, P.: Selective Radiation Therapy in Stage 1B Uterine Cervical Carcinoma Following Radical Pelvic Surgery, Gynecologic Oncology 10:84, 1980.
2. Adcock, L., Julian, T., Okagaki, T., et al: Carcinoma of Uterine Cervix FIGO Stage 1B, Gynecologic Oncology 14:199, 1982.
3. Allen, H.; Nisker, J., and Anderson, R.: Primary Surgical Treatment in One Hundred Ninety Five Cases of Stage 1B Carcinoma of Cervix, Am. J. Obst. Gynec. 143:581, 1982.
4. Barber, H.; Sommers, S.; Rotterdam, H., and Kwon, T.: Vascular Invasion as Prognostic Factor in Stage 1B Cancer of Cervix, Obst. Gynec. 52:343, 1978.
5. Blaustein, A.: Pathology of Female Genital Tract, New York, Springer-Verlag, 1982, 119-220.
6. Bleker, O.; Ketting, B.; Waysen-Eecen, B., and Kloosterman, G.: Significance of Microscopic Involvement of Parametrium and/or Pelvic Lymph Nodes in Cervical Cancer Stages 1B and IIA, Gynecologic Oncology 16:56, 1983.
7. Bostrom, S., and Hart, W.: Carcinomas of Cervix with Uterine Stromal Eosinophilia, Cancer 47:2887, 1981.
8. Chung, C., Nahhas, W., Stryker, J., et al: Analysis of Factors Contributing to Treatment Failures in Stage 1B and IIA Carcinoma of Cervix, Am. Obst. Gynec. 138:550, 1980.
9. Fuller, A.; Elliott, N.; Kosloff, C., and Lewis, J.: Lymph Node Metastases from Carcinoma of Cervix Stage IB and IIA: Implications for Prognosis and Treatment, Gynecologic Oncology 13:165, 1982.
10. Gauthier, P., Gore, I., Shingleton, H., et al: Identification of Histopathologic Risk Groups in Early Stage Cervical Cancer. Presented Annual Meeting Society of Gynecologic Oncologists, 1984.
11. Gynning, I.; Johnsson, J., and Trope, C.: Age and Prognosis in Stage IB Squamous Cell Carcinoma of Uterine Cervix, Gynecologic Oncology 15:18, 1983.
12. Hoskins, W., Ford, J., Lutz, M., et al: Radical Hysterectomy and Pelvic Lymphadenectomy for Management of Early Invasive Cancer of Cervix, Gyneeologic Oncology 4:278, 1976.
13. Iversen, T.; Kjorstad, K., and Martinbeau, P.: Treatment Results in Carcinoma of Cervix Stage 1B in a Total Population, Gynecologic Oncology 14:1, 1982.
14. Krebs, H., Helmkamp, F., Sevin, B., et al: Recurrent Cancer of Cervix Following Radical Hysterectomy and Pelvic Node Dissection, Obst. Gynec. 59:422, 1982.
15. Larsson, G.; Alm, P.; Gullberg, B. and Grundsell, H.: Prognostic Factors in Early Invasive Carcinoma of Uterine Cervix, Am. Obst. Gynec. 146:145, 1983.
16. Nahhas, W., Sharkey, F., Whitney, C., et al: Prognostic Significance of Vascular Channel Involvement and Deep Stromal Penetration in Early Cervical Carcinoma, AM. J. Clin. Oncology 6:259, 1983.
17. Papadimitriou, G.; Vlahoussis, A.; Papaloukas, E., and Midulla, I: Radical Surgery for Cancer of Uterine Cervix: Ten Year Experience, Int. Surg. 67:347, 1982.
18. Prempree, T.; Patanaphan, V.; Sewchand, W., and Scott, R.: Influence of Patient's Age and Tumor Grade on Prognosis of Carcinoma of Cervix, Cancerr 51:1764, 1983.
19. Shingleton, H., Gore, H., Soong, S., et al: Tumor Recurrence and Survival in Stage 1B Cancer of Cervix, Am. J. of Clin. Oncology 6:265, 1983.
20. Swan, D. and Roddick, J.: Clinical Pathologie Correlation of Cell Type Classification for Cervical Cancer, Am. J. Obst. Gynec. 116:666, 1973.
21. Van Hagell, J., Rayburn, W., Donaldson, E., et al: Therapeutic Implications of Patterns of Recurrence of Uterine Cervix, Cancer 44:2354, 1979.
22. Webb, M. and Symmonds, R.: Site of Recurrence of Cervical Cancer After Radical Hysterectomy, Am. J. Obst. Gynec. 138:813, 1980.
23. Wentz, W. and Lewis, G.: Correlation of Histologic Morphology and Survival in Cervical Cancer Following Radiation Therapy, Obst. Gynec. 26:228, 1965.

- Dr. Nuss, Director, Division of Gynecologic Oncology, University Hospital of Jacksonville, 655 West Eighth Street, Jacksonville 32209.


Among so many once-daily
antihypertensives,
only one can offer so much...


Introducing
The standout.
BRIDE

Once-daily INDERIDE® LA

The world's leading beta blocker and diuretic—for once-daily convenience without compromise

When selecting other once-daily agents, physicians may have to compromise either their choice of beta blocker or diuretic. With INDERIDE® LA, physicians have the agents most widely prescribed worldwide—INDERAL® and hydrochlorothiazide—with the convenience of once-daily dosage.

24-hour blood pressure control with the broad benefits of INDERAL (propranolol HCl)

The controlled-release delivery system of INDERIDE LA provides 24-hour beta blockade and the broad cardiovascular benefits of INDERAL with a single daily dose. Compliance is enhanced because once-daily administration fits easily into patients' daily routines.

Plus standard-release hydrochlorothiazide, the thiazide of choice for comfortable morning diuresis

Hydrochlorothiazide is the world's most widely prescribed antihypertensive diuretic. When taken in the morning, INDERIDE LA provides comfortable morning diuresis. Each dosage strength of INDERIDE LA contains:

–one of the three most widely prescribed dosage strengths of INDERAL® LA—80 mg, 120 mg, or 160 mg and

–an established, effective daily dose of standard-release hydrochlorothiazide—50 mg

New once-daily

INDERIDE® LA

lol HCl (INDERAL® LA),
hydrochlorothiazide, 50 mg

Convenience without compromise



80/50 120/50 160/50*

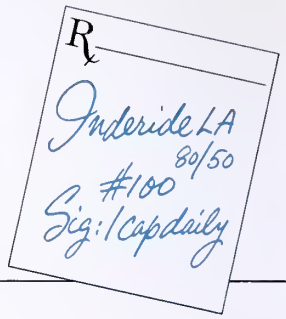
*The appearance of INDERIDE® LA Capsules is a registered trademark of Ayerst Laboratories.

Please see following page for brief summary of prescribing information.

Once-daily
INDERIDE® LA
Convenience without compromise
One capsule—Once daily



80/50 120/50 160/50*



* The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERIDE® LA Brand of **PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)**

No. 455—Each INDERIDE® LA 80/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 80 mg
Hydrochlorothiazide 50 mg

No. 457—Each INDERIDE® LA 120/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 120 mg
Hydrochlorothiazide 50 mg

No. 459—Each INDERIDE® LA 160/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 160 mg
Hydrochlorothiazide 50 mg

INDERIDE LA is indicated in the management of hypertension.

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias; headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity; rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

Ayerst® AYERST LABORATORIES
New York, NY 10017

Once-a-day

Getting ahead in medicine is an uphill climb.



Unless you have a BellSouth Mobility car phone.

Turn drive time into prep time. This year, our car phones are going to be one of the most popular ways for doctors to control high blood pressure—their own.

Because BellSouth Mobility cellular car phones allow doctors to stay in constant touch. To plan ahead. And to have the frustration of the pay-phone routine painlessly removed by allowing you to give your service an immediate buzz when you get beeped on the road.

Advanced service network. Ours is the most advanced phone system on wheels. It's just as easy to use as your office phone. And it's the only one with a state-of-the-art service network behind it. Making sure that your car phone—and your patience—are state-of-the-art. Now, and down the road.

Call BellSouth Mobility toll-free at 1-800-351-3355. And from there, it's all downhill.

BellSouth Mobility

All you need to know about mobile communications.℠

©1985 BellSouth Mobility Inc



WANTED

Board Certified physicians or finishing residents in the following specialties who desire an attractive alternative to civilian practice:

NEUROSURGERY
ORTHOPEDIC SURGERY

Positions are available at both Army teaching facilities and community hospitals throughout the Southeastern United States.

Every Army physician is a commissioned officer. The Army offers a rewarding practice without the burdens of malpractice insurance premiums and other non-medical distractions.

Army medicine provides a reasonable salary while stressing a good clinical practice. Some positions offer teaching appointments in an affiliated status with nearby civilian medical schools or teaching programs. The Army might be just the right prescription for you and your family.

To obtain more information on eligibility, salary, and fringe benefits write or call collect:



AMEDD Personnel Counselor
3101 Maguire Boulevard
Essex Building, Suite 166
Orlando, Florida 32803
(305) 896-0780

SPECIAL ARTICLE

Hospital medical staffs: the future is now

Thomas M. Daniel, M.D. and Robert W. Seligson

"These are times in which a genius would wish to live. It is not in the still calm of life that great challenges are formed. . . Great necessities call out great virtues." (Abigail to John Quincy Adams, 1780).

Organized medicine faces one of the most challenging periods in its history. Just as the medical milieu of 1910 prompted the Flexner report and the subsequent changes in the course of medical education, the medical milieu of the 1980's challenges organized medicine to re-examine the methods and delivery of medical care in this country. The environment is more dynamic and pressures for change are prevalent: increasing social demands, advancing technological capabilities, excessive levels of expectation demanding unerring excellence, entry onto the scene of medical entrepreneurs of entirely different definition, increasing groups and people in the medical delivery force pushing for equal professional recognition (and compensation) — all struggling for attention against a backdrop of an economy unable and unwilling to continue to commit increasing resources to meet their demands. As a result, new players have elbowed their way onto the stage: government and regulatory agencies and their hangers-on, industrial corporations and their benefit managers, HMO's, PPO's, IPA's, home health services, ambulatory care centers, and multihospital systems with sophisticated marketing techniques designed either as nonprofit organizations earning "surpluses" or for-profit organizations earning returns for stockholders.

Unfortunately their concerns center mainly on DOLLARS — their numbers, their sources, and their distribution. Since most of these dollars are spent on physicians and hospitals, these new players have forcefully interjected themselves into the interrelationship of these traditional allies and brought about increasing tensions. It is the management of the sometimes tumultuous results that has challenged the genius of organized medicine and been instrumental in a new emphasis on medical staffs and a reconfirmation, restatement, and even redefinition of medical staff organization, responsibility and function. Medical staffs being the composite of those practitioners involved, the direction of this new thrust will be greatly dependent on the knowledge, understanding, and participating cooperation of the individual physician.

Factors and effects • To understand the players and their actions, one must take into account the characteristics of our changing medical environment.

There has been an increase in the number of practicing physicians that will continue through the 1980's. In 1971 there were 152 physicians per 100,000 population compared with 194 physicians per 100,000 population in 1980. In 1969, there were approximately 6,300 medical group practices. By 1980, the

The Authors
THOMAS M. DANIEL, M.D.
ROBERT W. SELIGSON
Dr. Daniel is Chairman of the FMA Council on Hospital Medical Staffs and a practicing radiologist in Clearwater, and Mr. Seligson is FMA Director of Medical Economics, Jacksonville.

number had increased to over 10,800 with some 88,300 physicians practicing in group settings.[1] As the number of physicians increases, there is greater competition for patients and hospital staff positions. Boards are being pressured to close staffs. The Florida Hospital Association reports that in a July 1985 survey, 14% of responding hospitals have partially or entirely closed staffs, with two-thirds of those being permanently closed.

During the past decade there has been substantial growth in multi-hospital systems and for-profit hospitals. Florida is leading the way: among general hospitals there are currently 88 for-profit vs. 84 not-for-profit (some of which are managed by corporate chains), 45 state or local government and 42 specialty hospitals (some of which are proprietary). The 1985 *Directory of Proprietary Hospitals* lists 125 owned or managed hospitals in Florida (with an additional 23 to come on-line in 1985). Armed with better capital, they are now venturing into teaching and research, health insurance, and prepaid medical care plans. Some medical staffs are chafing under the increased power vested in their executives and boards over medical staff officers and functions as well as over individual physicians, including their practices and privileges. Because of capital advantage and the benefits of group purchasing savings, their ability to reduce losses by eliminating low volume services[9] and "tight ship" management, their growth trends may well continue, though on a statewide basis total numbers of hospitals will remain the same. Consolidation and change in management and/or ownership will substitute for construction. The threat to community and local government hospitals (and those physicians preferring that functional environment) is obvious.

More physicians are entering full-time, part-time, or negotiated contractual relationships with hospitals and alternate health care providers. In a survey conducted by the AMA in 1981, 191,000 physicians indicated they had contracts with hospitals or other health care facilities.[3] Many otherwise "private" practitioners have contractual relationships with hospitals through such things as EKG reading groups and managers of in-hospital programs (respiratory therapy, rehabilitation programs, utilization review, etc.). Frequently entered into for protection of income and patient base, contracts expose physicians to control by the contracting entities through economic pressure. The tools? Utilization review, management information systems, disallowances, contract renewal, and "compliance" with regulating entities (including JCAH) among others. Organized medicine has begun to address contractual relationships, providing information regarding contract options when negotiating with hospitals and others[14] and taking the position that such relationships should be "mutually agreeable, fair to parties involved, promote the interests of patients, and support the provision of high quality care and services."[3]

In many circumstances, physicians groups are considering "joint ventures" with hospitals and other organizations in delivering health care or participating in health related endeavors. These may take the form of simple contractual relationships, partnerships, or creation of corporate entities, but most have as their purpose pooling of capital, expertise, knowledge, and property resources for the purpose of engaging in a profit-making enterprise under joint control of the parties. They are so numerous and varied in type as to almost defy definition and have led to frustrations in attempts to develop guidelines for the ethical involvement of physicians.[15]

Reduction in funding from Federal and State government will eventually reduce hospital revenue significantly from inpatient sources. This will result in budgetary and equipment squeezes unfamiliar to most medical staffs in recent years.

Because of their economic structure, some hospitals are resistant to assume a large load of indigent patients, forcing them through the doors of those who by law or community commitment must accept such patients. Not only does this strain consciences in community hospital boardrooms and threaten increased tax burdens on a weary society, but some physicians are required to accept a larger share of these patients (and the economic losses) because of their affiliations.

Physicians, more accustomed to medical intellectual pursuits, are being coerced into traveling through the unaccustomed avenues (and alleys) of "market shares", "competitive pricing", "networking", "cost-effectiveness", "management information systems", and all the other concerns more familiar to business jounals than medical journals. They are being guided through this unfamiliar terrain by hospitals which need their assistance in the hospitals' quest for survival in a highly competitive horse race for house patients.

Physicians are entering in increasing numbers territory once reserved for hospitals — cataract centers, outpatient surgery centers, plastic surgery centers, and expanded office-based laboratory facilities. Hospitals, in turn, are encroaching on traditional physician-service areas — outpatient diagnostic centers, outpatient clinics, walk-in clinics, ambulatory care centers, alcohol and substance abuse programs. Hospitals gain the edge in this joust with huge advertising budgets and marketing expertise.

There is a predicted reversal of the former 60% — 40% split of the health care dollar in favor of the hospital to a future 40% — 60% split in favor of the physicians. Unfortunate for both, however, is the predicted overall decrease in health care dollars

which nullifies the physician's advantage and complicates the hospital's loss.

Hospital failures are predicted and have already begun. Each sinking hospital sets afloat another medical staff into the competitive sea.

Health care cost containment — one of the prime legislative issues on both the state and national level — threatens to adversely affect the type of care rendered in and out of the hospital. Physicians are deeply concerned over their ability to continue to deliver high quality care, and are worried events may turn as they have in Great Britain where decision making is frequently based on resource constrains rather than medical criteria.[6] British per capita daily expenditures of $173.96 vs. U.S. expenditures of $327.33[7] are bound to appear attractive to legislators facing the predictions of continuing escalation of costs because of technological advances and an increasingly aging population. As in Britain, rationing almost certainly will occur to some degree as government reduces reimbursement. Society and economic pressures will make the decision, but patients and physicians will be saddled with the results and the blame.

Major corporations are becoming more involved in directing health care cost containment and are participating in business health coalitions to address the issue. *U.S. New and World Report* reports that approximately 60% of the nation's top 500 companies have changed health benefits to encourage employees to shop around for the most cost-effective medical care;[4] in Chicago, employers include in employees pay envelopes "hit lists" of higher fee physicians to avoid!

Physicians have begun to look at their hospital differently. In an AMA survey, physicians identified the following as major hospital issues: (1) lack of medical staff voice in hospital planning and in hospital governing decisions, (2) effect of change in hospital ownership on medical staff, (3) competition between hospital ambulatory services and office based practices, (4) hospital diversification into other profit-making activities, (5) closed medical staff arrangement and/or exclusive contracts, (6) interpreting and complying with JCAH standards, (7) role of the non-physician health care provider in the hospital, (8) inter-specialty jurisdiction in privilege delineation, and (9) hospital cost-containment.

Physicians, more aware of the necessity for protection of their position in the hospital, are clamoring for membership on hospital boards and committees, exerting pressure on their own leaership to push for increasing positions of power.

The latest "attraction" on the medical liability marquee features increasing difficulty in obtaining coverage by physicians and hospitals alike. Relationships are strained as some physicians want to "go bare" while hospitals and their insurance carriers are not only demanding coverage as a condition of staff membership (now enacted into law in Florida) but in the view of most physicians and organized medicine groups are excessive in those demands.

The response • Physicians are attempting to return to a more authoritative role. Just as toward the end of the 19th century the profession became more cohesive as a result of scientific advancement and change in social structure (more dependent on one another for referrals and access to facilities), it is finding again that greater cohesiveness strengthens professional authority.[16] In a nationwide survey conducted by Northwestern University, a growing physician involvement in hospital management was indicated. The percentage of hospitals with physicians as voting members of their governing boards increased from 68% to 98% from 1972 to 1981. The survey also indicated that in 1981, 31% of hospitals surveyed had medical staff members on long-range planning committees. This clearly represents a renewed interest in participation in the formation of hospital policy.

Organized medicine is recognizing this need for greater involvment and cohesiveness. The AMA in 1981, after studying the relationship with hospitals and other health care facilities, established a special section to meet the peculiar needs of hospital medical staffs. The AMA Hospital Medical Staff Section meets bi-annually in conjunction with the AMA annual and interim meetings. The goals which have been established are: (1) to provide a forum for hospital medical staffs to meet nationally to discuss common issues and concerns, (2) to increase awareness of issues that are affecting physicians as members of medical staffs, (3) to ensure bi-directional communication between the AMA and medical staffs, and (4) to provide an avenue for direct access to the policymaking body of the AMA.

Subsequent to, and as a result of the development of the AMA Hospital Medical Staff Section, the Florida Medical Association Board of Governors created an ad hoc committee on March 1, 1984 to assess methods to establish medical staff representation within the structure of the FMA, with careful emphasis on including county medical societies in the process. This committee identified two major goals: to provide a forum for hospital medical staffs to meet on a statewide basis to discuss common issues and concerns, and to provide an avenue for direct access into the policymaking body of the FMA.

As a result, the FMA House of Delegates in 1984 adopted an amendment to the FMA Bylaws to provide for the creation of a Council on Hospital Medical Staffs composed of eight representatives (nominated by the county medical societies and representing equally the four medical districts) ap-

pointed by the Board of Governors, with the Council Chairman appointed by the President. The Council is given a representative and a vote in the House of Delegates in order to give it direct access to that body.

The Bylaws require the Council to hold two statewide meetings yearly to which a representative from each hospital medical staff in the state and the chairman of the county committee on Hospital Medical Staffs (which county medical societies have been asked to form) are encouraged to attend. These representatives are given "delegate" status which provides them with the privilege of the floor to introduce and discuss issues of common concern. The Council has begun to publish a quarterly newsletter, reporting its activity, and containing information of interest to medical staffs, which is disseminated to all chiefs of staff and county medical societies.

This extensive network ensures adequate opportunity for representation of medical staffs as an entity to organized medicine to study and address the problems of today. Obviously there is the danger of "excessive levels of expectation" but to date the enthusiastic cooperation of the House of Delegates, Board of Governors and staff has led to some impressive successes.

Time for involvment • What does all this tell us? It tells us that now is the time to get educated, get involved, and provide physician input to ensure that changes in the method of delivery of hospital care do not adversely affect the quality of care that is rendered. With predictions that hospitals will continue to gain control over the practice of medicine,[12] physicians must establish good working relationships with hospital administrators and governing boards with mutual respect for each other's roles. Working together in a united effort will allow individual physicians and organized medicine to help mold the rapidly changing system and ensure that physicians still have the power to be the advocate of the patient and provide the type and quality of care the patient deserves and has come to expect of the physicians of Florida.

References

1. A Guide for Formation of a Hospital Medical Staff Section, Chicago Illinois: American Medical Association, November, 1983.
2. "Hospitals — A Sick Industry," U.S. News and World Report, March 18, 1985, pp. 39, 40, and 45.
3. A Guide for Formation of a Hospital Medical Staff Section, Chicago, Illinois: American Medical Association, November 1983.
4. "Hospitals — A Sick Industry," U.S. News and World Report, March 18, 198S, pp. 39, 40, and 45.
5. "Fourteenth Periodic Survey of Physicians," Chicago, Illinois: American Medical Association.
6. Henry J. Aaron and William B. Schwartz: The Painful Prescription Rationing Hospital Care, Washington, D.C.: The Brookings Institution, 1984, pp. 34-35.
7. Jeremy W. Hurst: "Aggregate Comparison of the Performance of the American and British Health Sectors" (London: Department of Health and Social Security, n.d.), Table C-1, p. 8S.
8. The Environment of Medicine, AMA Council on Long Range Planning and Development, December 1983.
9. Rockwell Schulz and Alton C. Johnson: Management of Hospitals, New York: McGraw-Hill, 1983, p. 41.
10. Washington Health Costs Newsletter, Washington, D.C., Washington Business Information, Inc., May 24, 198S, p. 2.
11. Robert Teitelman, "The Disappearing Hospital," Forbes, June 3, 198S, p. 238-240.
12. Howard L. Lang: "Medical Staff Governing, or Whose House Is It Anyway?", California Physician, December 1984, pp. 16-18, 27.
13. Rockwell Schulz and Alton C. Johnson: Management of Hospitals, New York: McGraw-Hill, 1983, p. 95.
14. Physicians' Hospital Contracts, Chicago, Illinois: American Medical Association, 1983.
15. Board of Trustees Report "C", AMA House of Delegates, Chicago, Illinois: 198S.
16. Paul Starr: The Social Transformation of American Medicine, New York: Basic Books, Inc., 1982, p. 18.

• Dr. Daniel, P.O. Box 210, Martin Plant Hospital, Clearwater 33517.

Health Maintenance Organizations and the Medicare program

Lee A. Fischer, M.D.

On January 10, 1985, the Department of Health and Human Services published final regulations expanding health maintenance organizations (HMOs) to Medicare patients on a nationwide basis. Over the past two years, 21 demonstration projects have been enrolling Medicare recipients, the majority in south Florida. This article discusses our experience since the HMOs expanded into our county and what physicians across the nation can expect in the near future.

In December 1984, a few weeks prior to the January 1, 1984 start-up date, doctors and patients in Palm Beach County, Florida, were greeted with newspaper and television advertisements urging Medicare recipients to enroll in HMOs. As the concept of HMOs was new to our area, the ads explained that patients would receive free hospitalization, free doctors visits, free prescriptions, free eyeglasses, free hearing aides, and more with no premium, deductible, or coinsurance. All that was required to end one's worries over high medical bills was a valid Medicare card and a signature.

HMO demonstration projects had been operating in Dade and Broward counties (Miami and Ft. Lauderdale) for some time, but were slated to begin operation in Palm Beach County on January 1, 1984. For three weeks leading up to that date and for many weeks thereafter, expensive, double-page ads appeared in the newspaper touting this wonderful, new Medicare benefit. Local radio programs extolled the miracle of government-backed HMOs. Actor Glenn Ford followed later by Barbara Mandrell and George Burns appeared in TV commercials urging Medicare recipients to "get all the facts. I did." Television news dutifully recorded long lines of elderly people waiting literally in rain or shine for up to three hours for the privilege of enrolling. Local promoters publicly gloated that now they and their Medicare enrollees were going to get back at private practice physicians for all the years of abuse they had suffered. Not only doctors but also many responsible senior citizens became concerned about the propaganda blitz paid for with federal dollars.

Public awareness campaign • A few weeks of costly advertising by the HMOs was enough to convince most of us that the public was getting a one-sided view. With the support of members, the Palm Beach County Medical Society embarked on a public awareness campaign to counter the claims made by the HMOs. We used the professional expertise of a local public relations firm to put our program together, and after many meetings our campaign began, involving newspaper ads, radio spots and public speaking. The success we achieved was directly related to the professional help and guidance we received.

In late January we appeared on our "Call the Doctor" weekly TV show and explained some of the facts that we felt Medicare recipients should consider prior to joining an HMO. A few weeks later our first full-page newspaper ad ran in the Sunday edition. It urged people to get all the facts before joining an HMO, including the fact that their choice of

The Author
LEE A. FISCHER, M.D.
Dr. Fischer is in private family practice and is Immediate Past President of the Palm Beach County Medical Society.

physician and hospital was severely limited. Because many residents of our area spend long periods up north in the summer, we pointed out that only "emergency" and "urgently needed" care would be covered by the HMO while they were away from the area. Prospective enrollees were urged to ask the HMO to define these terms. Because many HMO centers refused to list the names of the doctors working for them, we urged people to ask for the doctors' names, medical society membership and hospital affiliation (if any), and board certification. After all, no matter who owns or runs an HMO, only licensed physicians can actually practice medicine. We provided a list of other essential questions people should ask.

The radio spots ran on two AM talk radio stations. They were short sketches depicting potential problems enrollees might encounter in an HMO. For example, a lady discussed how she would not be going to her summer home up north this year because she had enrolled in an HMO and was afraid that if she got sick she could only be treated in an emergency. She did not want to take the chance of getting sick and finding out later that the HMO would not authorize or pay for her care.

Over a ten-week period our newspaper and radio spots focused attention on the fact that all glitters is not gold. Once people realized that the decision to join an HMO was at least controversial, they began to seek more information. That is where our public speaking program proved highly successful. Medical society members spoke before more than 2,000 people in the six months after the HMOs began in our county. The meetings varied in size from groups of 20 to over 300. Some sessions presented only our side while others were quasidebates with the HMO viewpoint presented by a local HMO representative. It was interesting to see how the groups' attitudes changed over time. At first many questions were directed at us, obviously skeptical of our involvement. The usual comment was that doctors were opposing HMOs because they were losing patients to them. A few months later, however, skeptical questions were being directed at the HMO representative. As enrollees began to have problems, they told their neighbors, and word spreads fast in a retirement community. Many people found themselves enrolled without their knowledge. Others were unable to disenroll and return to the regular Medicare program even after five months of trying due to bureaucratic bungling. In some cases the quality and continuity of care was not what patients had expected. After the early rush to enroll, thousands began to disenroll.

Public's problems and complaints • Much has happened since our public awareness campaign ended in June 1984. Over the past year our medical society received numerous complaints from patients who had problems with local HMOs, and these complaints were forwarded to the appropriate authorities. In July 1984 our congressman held a field hearing of the House Select Committee on Aging and heard testimony from consumers, HMO operators and medical society representatives. We documented numerous problems and complaints and presented them in our public testimony to the committee. The complaints fell into five areas; enrollment tactics, disenrollment problems, continuity of care, quality of care, and resolution of patient problems. A few representative examples will illustrate these problem areas.

Many people complained about the enrollment tactics employed by the HMOs. Numerous reports were received from people who sent in a request for further information only to find out they were subsequently enrolled without their knowledge. An HMO set up a table outside a local giveaway of government surplus cheese to indigents and enrolled individuals who were asked if they wanted a free pair of eyeglasses and some free medicine. One gentleman did not even sign his own name and was not given any material concerning benefits or information as to the center to which he was assigned. Others were enrolled by HMO employees going door to door in retirement communities. Many people first discovered that they were enrolled after submitting a claim to Medicare which was denied. The initial goal seemed to be enroll as many people as possible and worry about delivering medical care later.

If enrollment was sometimes too easy, disenrollment could be extremely difficult. The standard HMO line is that one can disenroll and be back on regular Medicare in two to six weeks. In reality many enrollees waited up to six months. People who live up north part of the year were encouraged to disenroll four weeks prior to their departure and get back on regular Medicare, and then to reenroll in the HMO upon their return later in the year. One gentleman who testified at the federal hearing enrolled on December 6, decided to disenroll on December 9, and finally got back on Medicare May 1, 1984, although he had written numerous letters, made numerous phone calls and traveled to the HMO home office 60 miles away in an effort to disenroll. Others received notification from the HMO that they would be back on regular Medicare by a certain date only to find out later that the computer still showed them enrolled in the HMO. In many cases the patient was caught in the middle not knowing who was responsible for paying the bills. A recently released report by the United States General Accounting Office (GAO) found this area to be a major concern and urged the Department of Health and Human Services to correct these problems immediately.

Continuity of care is a necessity when caring for the Medicare population, many of whom suffer chronic illnesses. Continuity of care has been found sorely lacking in some of HMOs in Palm Beach County. A number of the HMO centers are free-standing emergency clinics that employ physicians on an hourly or part-time basis. The doctor there today will not necessarily be the one there tomorrow, leading to a lack of continuous, ongoing care in a most vulnerable population group. Some HMO doctors are semiretired and return north for the entire summer. Many HMO physicians have no hospital privileges and thus must rely on private physicians on call for the emergency room to care for HMO patients when they need to be hospitalized. This fragmentation of the patient's medical care can have serious consequences.

The quality of medical care is a difficult area to evaluate. Because there is a financial incentive to deliberately underutilize services, there is great concern that in some cases the standard of care is different in HMOs than the standard of care that prevails in our community. Additionally much use is made of ancillary personnel to deliver medical care posing serious questions concerning their supervision.

Many people who could not resolve their problems with the HMO called and wrote our medical society because they had no where else to turn. As insurance plans, HMOs are regulated by the state Insurance Commissioner but his office tends to pass the buck to the Health Care Financing Administration (HCFA) which runs the Medicare program. The patient, of course, is caught in the middle. In our testimony to the Committee on Aging we presented problems ranging from people who simply were unsatisfied with the care they received to others who found themselves personally responsible for thousands of dollars in medical bills.

Measuring success • Measuring the success of a program such as ours is not easy, but while taping a TV show during July 1984 I realized how informative our program had been for senior citizens. The show was a question and answer panel discussion on HMOs, but the TV station also videotaped local man-in-the-street interviews with senior citizens and asked them a number of questions about HMOs. Their answers sounded as if they were reading straight from our information. Prior to our campaign none of those people would have been able to answer as they did. At that point I knew we had accomplished our goal which was to insure that prospective enrollees had all the facts with which to make an informed decision. After listening to the comments on videotape it was obvious that our mission had been a complete success.

Not only was our campaign successful with the Medicare population but it succeeded in forcing the media and government agencies to recognize that problems did indeed exist. Recently the state Insurance Commissioner proposed legislation to strengthen the laws regulating HMOs. The first GAO report highly critical of HCFA's administration of the program has been released with another part of the report in progress. The Palm Beach County Medical Society submitted comments to HCFA on the proposed rules in July 1984 and was gratified to see that some important changes were made in the final rules implementing the program nationwide.

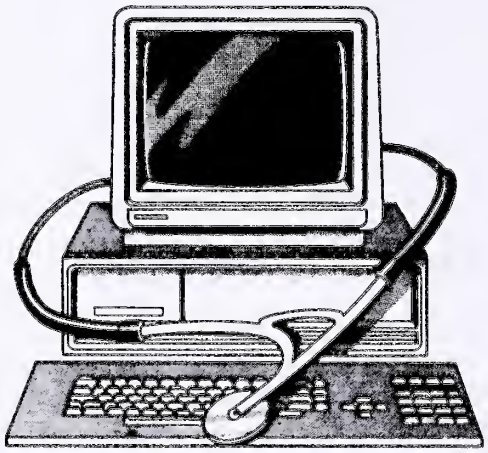
Are the problems we encountered in Florida with the HMO demonstration projects a preview of what will happen in the remainder of the country in the next year? On the basis of our experience we feel that nationwide implementation of Medicare HMOs is premature based on the problems we encountered and the fact that the evaluations commissioned by HCFA will not be ready for at least one year. Does anyone know the consequences of expanding this system across the country? Will senior citizens really receive quality medical care, or are HMOs just paying lip-service to the concept, while deliberately underutilizing services to maximize profit? Serious questions have been raised that demand truthful answers. Other county medical societies will most certainly be placed in the same position we were and it will be up to all concerned physicians to insure that quality health care is maintained. We urge each county society to be the patient's advocate and as the need arises to make the facts known to the public. The health and well-being of our senior citizens are too important to leave to chance.

• Dr. Fischer, 1825 Forest Hill Boulevard, West Palm Beach 33406.

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Inquisition of the Medicare physician reimbursement system

The successful imposition of Diagnosis Related Groups (DRGs) upon hospitals has enticed the federal bureaucracy to tinker with physician fee-for-service payments as an antidote to redress the hypothetical "crisis in physician fee escalation." I would like to inventory the warehouse of rationales for the reimbursement schemes now undergoing consideration.

Why change what works? • Most people, including President Reagan, assert that the American medical system is the finest ever devised.[1] Physicians defend the fee-for-service system as the propellant to the creation and maintenance of such excellence. Why, therefore, would an administration, which professes a credo of less government intervention, want to disfigure and maim the medical system with restrictive regulations? Their catalogue of reasons contains several arguments.

1. Fee-for-service reimbursement, based upon cost plus or Usual-Customary-Reasonable (UCR) fee schedules, is viewed as inflationary. Physicians are perceived as the economic beneficiaries of acclerated patient use of this system. Costs can be passed on to patients and through patients to the government because there are no economic modulators which can enkindle efficiency and tame over-utilization.[2]

2. Medical care is warped towards the use of high technology, specialists and procedural intervention which further exaggerates costs.

3. The system lacks uniformity in fee schedules. For instance, in 1980 the prevailing surgical fee for coronary bypass surgery was $5500 in urban Kentucky but $2500 in Kansas City, Kansas. The professional fee component for cardiac catheterization was $540 in Kansas City but $370 in Mobile, Alabama. A rapid perusal of prevailing charges by the Health Care Financing Administration (HCFA) reveals a multitude of such geographic distortions in charges.[3] The fee differences are not small.

4. Utilization rates for procedures differ from region to region or even from locale to locale in the same state.

5. Fiscal administrators for Medicare are fickle in adjudicating allowances for services. Amounts paid vary from month to month for the same procedure by the same physician for the same patient.

6. The conscientious physician who attempts to maintain fees at a low level is not only unrewarded but also is penalized by the current Medicare freeze.

7. Geographic maldistribution of physicians is aggravated since the system allures doctors to larger, more densely populated urban areas in which high technology, higher density of specialists and higher fees congregate.

Such inequities and dissonance of perception have permeated the Medicare system with confusion, uncertainty and injustice. All criticisms from patients, physicians, payers and government are justifiable to some extent. Excessive blame for Medicare's rising costs, however, is being attributed to doctors, when the physicians' portion of Medicare costs increased only 1% (from 21.4 to 22.4%) from 1975-1982[4] — hardly a quantum leap. During the decade of the 1970s, the cost of physician services rose only 1.7% (in constant 1979 dollars), and the percent increase in total fees paid to physicians was nearly identical to that for lawyers, accountants and engineers during the same decade. This small increment should be contrasted with the 20% increase in real, uninflated per capita income enjoyed by the rest of the American population during the same decade.[5]

Physicians also are blamed for the fact that medical care consumes 10.5% of the gross national product (GNP), but no percentage of GNP can be construed as proper or improper. Economic forces and demand for medical services (not government fiat) will determine the portion of GNP consumed by medical care.

People somehow misconstrue the utilization of high technology and specialists with the economic bedevilment of the medical system. They fail to adjust their intellectual bias to the coincident rise in patient longevity and the improvement in quality of life that has paralleled the surge in technology and specialization.

What are the alternative methods of reimbursing physicians? • Medicare is experimenting with prepaid capitation within the framework of Health Maintenance Organizations (HMOs). Budgetary directors favor capitation because it permits a precise estimate of the total cots of health services for a given population over a given period of time. Total capitation, however, is unlikely because it is unacceptable to physicians, will encourage shortening of time spent with patients, and will erode quality of and access to medical care.

Variations upon the capitation theme are several, and proposals for extending DRG-type reimbursement to physicians have been undergoing intense discussion since DRGs were successfully applied to hospitals. Extending the DRG concept to physician services, however, is tainted with multiple uncertainties and, since a physician DRG program has never been tried experimentally, there is no assurance that it would actually save Medicare any money. Also, it would be burdensome to administer, and there is no concensus as to who should disseminate the funds to the physicians involved in the care of a patient. Should the funds be given to the hospital, to the family physician, to the medical society, or to the local Medicare fiscal administrator? It has been hypothesised that money could be saved by making the family physician the gatekeeper. The family physician would be alloted a fixed sum to care for a patient with a given diagnosis and would disperse monies to pay for the services of consultants. In the only study in which the family physician served as gatekeeper, the gatekeeper system proved more expensive than traditional medical care, and the cost savings potential of such a system remains questionable.[6] Furthermore, endowing the family physician with most or all of the physician funds would encourage under-utilization of specialty services, threaten quality of care, and bring about an internecine conflict among providers. This would produce an "open season" for malpractice lawyers to parasitize the resulting chaos.

Additional questions have been posited. Should the DRG-type system be applied only to hospitalized patients, or should outpatient physician services by included? The unknowns which enshroud this have caused many health policy economists to retreat from recommending DRG-type reimbursement for physicians.

Some people have suggested that Medicare cost savings could be achieved by simplifying the payment system and bundling together groups of services. For instance, all office visits would be assigned one code and permitted one payment amount in spite of the complexity of the problem or length of the visit. Hospital visits and laboratory services similarly would be aggregated into one or very few "bundles." The myraid codes for surgical procedures which now exist would be abolished and replaced by a more streamline, leaner list of procedures.

Others have proposed the application of physician DRGs only to hospital-based physicians, such as pathologists, anesthesiologists and radiologists. This idea would reduce the administrative costs of Medicare by appending the physician payment to the hospital DRG payment. It is reasonably certain that hospital-based physicians will not embrace a system that is so prejudiced against them.

None of the above proposals assure economic savings, resolve the geographic maldistribution of physicians, assure quality of care or equalize access to medical care. They may reduce some of the distortions in fees paid to physicians for a given procedure, but they also may substitute other inequities. For example, care for the complex patient will be underpaid and, thus, the more severely ill patients will be abandoned and avoided.

Some of these proposals may permit the government to constrain the increase in cost of services by establishing a pre-set, maximum payment for a group of services. Some may remove the uncertainty regarding the amount of reimbursement that now exists. Also, it is assumed that the above proposals will reward efficiency by permitting the low-cost supplier of services to enjoy a larger profit than the currently-more-expensive supplier. Absent from all of these proposals is any concern for the quality of care or assurance of patient access to the system.

Many government folk would like to impress mandatory assignment on all Medicare providers. This may be applicable to certain surgical subspecialists who are generously remunerated for their services, but this would gravely burden the family physician whose fee is currently being reimbursed by Medicare at a rate of only 45 to 50%. Such a low rate of reimbursement for the family physician does not cover overhead costs, and it certainly does not reward him for his time, skills or investment which has been made toward his education or office equipment. Physicians cannot be expected to assume

society's obligations; thus, they will stop accepting Medicare patients, and these patients will be denied both access and quality care.

The AMA is hoping to divert the energies and dilute the frenzies engendered by DRGs and other reimbursement proposals by offering its alternative: national or regional fee schedules. The AMA and Harvard University recently applied for a grant from HCFA to research the feasibility of establishing a national relative value scale (RVS). The conversion factor used to translate the RVS into fees probably will have to be regionalized, but such a schedule would eliminate the vast discrepancies in fees for given services that now exist across the nation. It would remove reimbursement uncertainty for the patient, the physician and the government, and it would provide health care economists with firmer data to insert into their projections of physician costs. Potentially a RVS could help curtail excessive inflation in physician fee reimbursement and concurrently maintain the fee-for-service principle. If such a RVS had a clause allowing for economic inflation, it would be a satisfactory compromise for most physicians.[7]

Potential disadvantages to a national RVS system would include the following possibilities. (1) It could contain poorly-designed geographic costs differentials (in items such as rent and taxes) which may not be properly weighted and would not adequately compensate physicians who practice in high overhead areas. (2) The establishment of a national fee schedule would be a violation of antitrust law, and some legal means of circumventing this impediment would have to be found before such a system could be implemented. (3) Historically the Medicare bureaucracy has demonstrated that it is likely to impose discounts on the amount of any fee it will reimburse. Using history as our teacher, some form of balance building would have to be written into the system to keep Medicare fees aligned with other consumer services and commodities; otherwise, any new system would suffer from the same reibursement inequities which exist with the present system and the elderly again would be threatened with substandard care.

The present system of Medicare reimbursement is decrepit and has been likened to an old horse which humanely should be destroyed and dumped upon the trash heap of failed sociologic experiments. That analogy is unrealistically harsh. I would prefer to compare it to a musty, maderized, old Burgundy wine. Because it has passed beyond its prime, there is no reason to uproot the vines and burn the chateau. With forethought, care, experimentation and time one can always harvest a fresh crop and produce a more robust vintage.

Acknowledgment

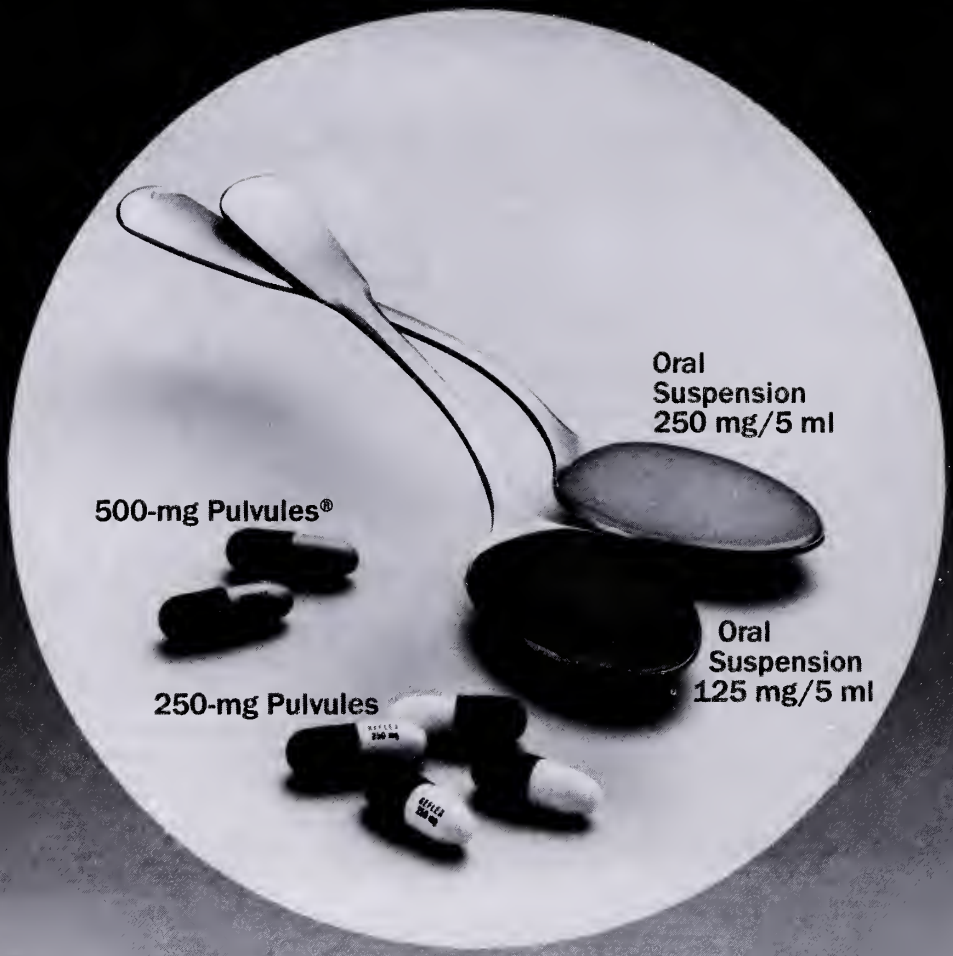
The author is particularly indebted to Drs. J. Hadley and M. Segal.

References

1. Reagan, R.W.: Address of the President of the United States to the AMA House of Delegates, Thursday, June 23, 1983.
2. Hadley, J.: How Should Medicare Pay Physicians? Milbank Memorial Fund Quarterly 62:279-299, 1984.
3. Health Care Financing Administration: Directory of Prevailing Charges. Department of Health & Human Services Publication (HCFA) 1007. Government Printing Office, 1981.
4. Hadley, J., op. cit.
5. Sloan, F.A., and Schwartz, W.B.: More Doctors: What Will They Cost? J.A.M.A. 249:766-769, 1983.
6. Moore, S.H., Martin, D.P., and Richardson, W.C.: Does the Primary Care Gatekeeper Control the Cost of Health Care? Lessons from the SAFECO Experience. New Engl. J. Med. 309:1400-1404, 1983.
7. Segal, M.: The Reformation of Physician Reimbursement. Address presented to the Volusia County Medical Society, Daytona Beach, Florida, August 13, 1985.

Jacques R. Caldwell, M.D.
Daytona Beach

Easy To Take



Keflex®
cephalexin

Additional information available to the profession on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 785
- ☐ DEAN'S MESSAGE, 787
- ☐ ENCORES!, 788
- ☐ SCAM OF THE MONTH, 791

NOTES & NEWS

Suncoast gerontology center receives $150,000 grant

The Administration on Aging, a Federal agency, has awarded a $150,000 grant to USF's Suncoast Gerontology Center to conduct a 15-month project entitled "Training and Placing In-Home Respite Care Workers for Alzheimer's Patients."

Families who have the major care responsibilities for patients with Alzheimer's Disease experience physical, emotional and financial hardships in their roles as primary caregivers. The respite care training project is an attempt to offer affordable, specially trained workers in the homes of Alzheimer's patients to provide care while giving the family caregivers a respite from patient responsibilities.

The Suncoast Gerontology Center will conduct this training program in conjunction with the Working Seniors Program of Hillsborough County Aging Services, West Central Golden Services, and the Greater Tampa Chapter of the Alzheimer's Disease and Related Disorders Association. Persons interested in becoming trained Alzheimer's Disease respite care workers or families in need of such specially trained workers should contact Lillian Middleton, Project Director, at the USF Suncoast Gerontology Center (813-974-3100) or Jeanne Smith, Program Director of The Working Seniors Program, who will recruit and screen potential trainees.

The Alzheimer's Disease in-home respite training project is limited to Hillsborough County residents. Trainees will receive minimum wage during a four-week, 80-hour training period, after which they will be assisted in finding families in need of their skills at a pay rate to be negotiated between the respite care worker and the family in need of services.

The USF Suncoast Gerontology Center, directed by Eric Pfeiffer, M.D., offers information and assistance to families of Alzheimer's Disease patients through family support groups, specialized memory disorder evaluation clinics, family counseling and co-sponsorship of a specialized dementia adult day care program in Pinellas County.

Arthritis endowment by UF graduate Lewis Schott brings major boost to arthritis research

A million-dollar boost for arthritis research at the University of Florida College of Medicine comes with establishment of an Eminent Scholars Chair to which a UF alumnus has contributed half the funding.

University President Marshall Criser announced on August 23 that the generous $500,000 contribution of UF law graduate Lewis M. Schott of New York City provided an initiative which inspired other private donors to give an additional $100,000. The chair is now fully endowed, with the allocation of $400,000 in matching money from Florida's Eminent Scholar's Trust Fund.

The new faculty position is being named in honor of Lewis Schott's wife, Marcia Whitney Schott, a native of Jacksonville who graduated from UF's College of Law along with her husband in the class of 1946. The endowment becomes the 30th Eminent Scholars Chair to be committed at UF since state legislators established the matching trust program in 1979.

Criser also announced appointment this week of a search committee, headed by UF physician Dr. James G. McGuigan (chairman of the Department of Medicine) to recruit a world-class scientist to fill the position.

"Lewis Schott's expression of concern for this area of research, through his major contribution, will enable UF's Health Science Center to become a leader in the field of rheumatic disease," said Dr. William B. Deal, Dean of the College of Medicine. "Some 1.4 million Florida residents and more than 31 million Americans are afflicted with some form of this inflammatory disease which is a leading and costly cause of pain and disability," he said.

Dr. David R. Challoner, UF Vice President for Health Affairs, added, "Despite major advances in understanding rheumatic diseases and advances in our ability to treat symptoms, scientists still have not identified a means of cure or prevention. With the Schott chair, we can give far more attention to specific aspects of basic and clinical arthritis research," he said.

Schott, who is a native of Daytona Beach, directs a variety of business enterprises in New York City. He keeps close ties with Florida friends and family, including his mother, Mrs. Matilda Ferguson, who still resides in Daytona Beach.

Schott's affiliation with UF began more than 40 years ago when he earned his B.A. degree here in 1943 and three years later, graduated with honors from the College of Law. Over the years, he has continued to maintain contact with his alma mater and to express great interest and support for the university's programs.

Other major commitments for the chair came from Mr. and Mrs. M.M. Parrish of Gainesville, the Florida Chapter of Arthritis Foundation, headquartered in Bradenton, and Alfred A. McKethan of Brooksville.

The AMA Market Area Profile (MAP) Service

The American Medical Association has announced a new activity that will be of interest to any physician who is interested in developing or modifying a medical practice. The AMA Market Area Profile (MAP) Service, created as a part of the Association's Competition Action Plan, is designed to assist physicians in establishing and maintaining a successful medical practice by providing them with detailed demographic and health resource data on an existing or planned practice site.

The MAP Service offers physicians individualized, computer-generated data profiles on any area in the United States. Each Market Area Profile consists of six data reports:

- The Area Profile Report — 1980 census data (e.g. population, age, sex, housing, occupation, income, etc.) for the area that the physician has selected.
- The State Area Profile Report — 1980 census data for the state in which the physician-selected area is located, provided for comparison purposes.
- The Demographic Trends Report — 1980, current year, and five year projected population and demographic data (e.g. population, age, sex, household size, etc.).
- The State Demographic Trends Report — A Trends report for the state in which the selected area is located, provided for comparison purposes.
- The Physician Report — Statistical information on the number of physicians in the area, by medical specialty, age, and major professional activity.
- The Hospital Report — Detailed information on hospitals in the selected area, including: number of beds; admissions, utilization and census figures; facilities and services; and a profile of the medical staff. (If there are more than four hospitals in the selected area, a summary listing of the hospitals is provided instead.)

The information provided in a MAP profile can be beneficial to all physicians, no matter what their practice situation. New physicians will find it helpful in practice site selectin decisions, whether they are investigating specific practice opportunities or comparing several practice sites. Established physicians can use the profiles to make decisions about expanding, relocating or modifying an existing practice. For example, a physician might wish to use the MAP demographic reports to compare his current patient base with the potential patient population of the communty. Another physician might want to study the five year projected population figures as part of the development of a long range practice plan. In any event, the Market Area Profile Service is a valuable planning tool that can help any physician make the right decisions about a medical practice.

A key feature of the MAP Service is the flexibility offered to the physician subscriber in selecting the area to be profiled. There are four choices: (1) County, (2) ZIP Code, (3) City/Town, or (4) Ring Study. The Ring Study option is a unique aspect of the MAP Service that allows the physician to precisely define the area of study in relation to an existing or planned office site. Using a specific street intersection as the center point, the physician can define the area as a ring of any size (for example, five or ten miles) around that intersection. This is extremely useful in instances where a standard geographic description does not adequately describe a physician's service area.

The cost of the Market Area Profile Service ranges from $95 to $195, with substantial discounts for AMA members, medical students and residents. Along with the six profile reports, physicians receive a User's Manual that provides data source information and offers useful advice on how to interpret and apply the data to a practice situation.

For further information, and to receive the MAP Registration Package, please contact the AMA Market Area Profile Service, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610, (312) 645-4719.

DEAN'S MESSAGE

Physician and patient

Editor's Note: Address delivered before Second Annual University of Miami School of Medicine, Student Council Student Convention, April 9, 1985

According to Norman Cousins, Thomas Mann, the great novelist, once began a lecture by saying that the most important thing he had to say was that he had nothing new to say. Let me add that this will hold true of my talk today which is based largely on the teachings of Norman Cousins, Francis Peabody, and Sir William Osler.

Peabody believed that one cannot become a skillful practitioner of medicine in the four or five years allotted to the medical curriculum. "Medicine is not a trade to be learned, but a profession to be entered. It is an ever widening field that requires continued study and prolonged experience in close contact with the sick." The novelist Eugene O'Neill stated that, "as long as you have a job on hand that absorbs all your mental energy, you haven't much worry to spare over other things. It serves as a suit of armor."

In his classical treatise, Peabody stated that the secret of the care of the patient was in caring for the patient. He stressed the importance of devoting time to the patient; "time to have little talks with him and time to know him as a man, his work and his play." Cousins has also emphasized the importance of devoting time to patients; "time to be heard, time to have things explained, time to be reassured." There is an old saying that, "it is much more important to know what sort of a patient has a disease than what sort of disease a patient has." (Quoted by Blumer).

In his famous address, "Aequanimitas", Sir William Osler pointed out the necessity of imperturbability on the part of the physician. The physician who has the misfortune to be without it, who betrays indecision and worry, who shows that he is flustered and flurried in ordinary circumstances loses the confidence of his patients.

The eminent Harvard physiologist, Walter Cannon, stated that a great service which the physician renders is that of bringing hope and good cheer to his patients. Eugene O'Neill stated that, "hope is the most powerful force on earth and the only thing that defeats death."

The ancient physicians were well aware that it is natural for the human body to heal itself, and that this process can take place without the intervention of a physician (vis medicatrix naturae). The late Franz Ingelfinger was emphatic that what patients need most of all is assurance that their own healing systems are beautifully designed to handle most of their complaints. He believed that 85% of patients the physician is called upon to treat have self-limiting illnesses and that the doctor's job is to distinguish between the 85% that really do not need his ministrations and the 15% that do.

Cousins has well stated that being able to diagnose correctly is a good test of medical competence, but being able to tell the patient what he or she has to know is a good test of medical artistry. Oliver Wendell Holmes believed that successful medical practice requires not lying but an ability by the physician to "round the sharp corners of truth." The truth can be told in a manner as to "lead the way to challenge or set the stage for shattering defeat" (Cousins).

It may be difficult to decide just what to tell the patient with an incurable disease. I recall the case of a prominent business executive and friend who was found to have an inoperable abdominal tumor. His wife had had an abdominal perineal resection for a rectal cancer and he told me that if he ever developed a cancer, he would kill himself. In addition, his wife had strongly insisted that I withhold the truth. Accordingly, I explained to him that he had a gastric ulcer invading his pancreas.

At that time, the late Dr. William Altemeier, who had operated on him, informed me that 5 hydrouracil was being introduced for the treatment of malignant tumors and that it was available in only two clinics: the Sloan Kettering Memorial Institute for Cancer and Allied Diseases and the University of Wisconsin. I chose the latter (to avoid the designation of cancer) and accompanied my patient to Madison where I was informed that he would have to be told the truth before they would institute treatment, and what did I want to do about it? I unhesitatingly gave them the green light. Instead of despairing, my patient mustered great courage and fought valiantly during the remaining year of his life, much of which was spent in the hospital where he held regular board meetings even during intravenous alimentation. He was elated that the year had proved so profitable for his company and more than covered his hospital expenses!

I often recall the case of a retired Army Colonel suffering with pernicious anemia, at the time, uniformly fatal. My Chief at the Cincinnati General Hospital, Roger S. Morris, sustained him with multiple blood transfusions until the discovery of a cure in the form of calves' liver. I relate this experience to patients with incurable diseases, pointing out that much research is being carried out that applies to their case. And, furthermore, histologic evidence interpreted as indicating a malignant

lesions may, at times, prove erroneous and that some malignant lesions may be very slowly progressive and not beyond the realm of rarely resolving.

It is noteworthy that the courageous Harvard bacteriologist, Hans Zinsser, fully aware that he was dying of leukemia, consoled himself with the thought that he would be spared the ravages of old age!

Osler believed that the physician needs a clear head and a kind heart; his work is arduous and complex, requiring the very highest faculties of the mind, while constantly appealing to the emotions and finer feelings. This great teacher had three personal ideals quite worth emulating: one, to do the day's work well and not to bother about tomorrow; second, to enact the golden rule toward his professional brethren and toward the patients committed to his care and, last, to cultivate a measure of equanamity to enable him to bear success with humility, the affection of his friends with pride, and be ready when the day of sorrow and grief comes to meet it with the courage befitting a man.

Cousins has been a leading advocate of the value of hearty laughter on the healing process so well illustrated in his *Anatomy of an Illness*. He attributes this possibly to the effect of emotions on the body hormones. Sir William Osler regarded laugter as the "music of life" and, according to Harvey Cushing, advised doctors who are spiritually and physically depleted at the end of a long day to find their own medicine in mirth. Paskind showed that laughter actually reduces muscle tone.

Emanuel Libman, a famous clinician, once said, "the physician as of old remains the student and even when he becomes the teacher still remains the student."

Prepare to remain students the rest of your lives and may the passing years prove healthful and richly rewarding.

God bless you all!

Leon Schiff, M.D., Ph.D., M.A.C.P.
Division of Hepatology
University of Miami School of Medicine

The author wishes to express his gratitude to Norman Cousins for reviewing this manuscript.

ENCORES!

Liability nightmare

"Item: A man sticks his two-year-old son's head between the running blades of a ceiling fan — and then sues the manufacturer for failing to warn him the child might be injured.

"Item: A company that had manufactured textile machinery for 136 years goes out of business because of the costs of liability lawsuits over equipment it had manufactured decades earlier.

"Item: After deciding that a drug a woman had taken during pregnancy was not responsible for her child's birth defects, a jury awarded her damages anyway — to help defray medical costs of the child's future care."

These horror stories, culled by a Heritage Foundation researcher, show why product-liability law has become a menace to more than just the Manvilles and Union Carbides of the world. Even without a single obvious disaster, the case-by-case costs of litigation can drive small companies to the wall. Heritage analyst Milton Copulos says 20 per cent of the cost of an ordinary stepladder is traceable to past, present, and future liability.

Sad to say, the horror stories are not mere flukes; each one illustrates a principle of law. The ceiling-fan case is just one example of how courts are disallowing the traditional defense of contributory negligence. Another such case involved a man who strapped a refrigerator to his back and ran a stunt footrace. One of the straps failed, and he collected $1 million from the strap manufacturer.

The textile-machinery case shows how a company can be assessed damages for injuries caused by long-forgotten, impossible-to-track-down products. The drug case typifies the new doctrine of generic liability, under which a consumer who suffers side-effects after taking a pill and cannot remember which brand he took can successfully sue all the makers of the compound in question.

The big winners — did you have any doubt? — are the lawyers. A Rand study found that a typical court case cost $380,000, of which $125,000 went to the defense lawyers, $114,000 to the plaintiff's lawyers, and $141,000 in net compensation to the plaintiff.

One of the ironies of the liability spiral is that in some areas it is making life more risky as well as more expensive. Sears was sued by a heart-attack victim who claimed that its lawnmower starter cord was too hard to pull; but rectifying this "defect" would make it easier for children to endanger themselves by activating the machines. Edmund Kitch, writing in a recent issue of *Regulation*, tells how liability for rare side-effects is driving many manufacturers out of the vaccine market, even in cases where united medical opinion agrees that the vaccines do more good than harm overall.

The diphtheria-tetanus-whooping-cough vaccine for children now costs $2.80 a dose and rising, up from ten cents a while back. Worse yet is the problem of "orphan vaccines." Although medical research continues to progress toward the hope of vaccines against AIDS and herpes, Kitch says that

"testing and obtaining regulatory clearance for such vaccines is not currently of interest to any potential producer. Those invisible non-litigants who would benefit from new vaccines are probably the most dramatic victims of the threat of product-liability law."

Reprinted with permission from *National Review*, August 23, 1985, page 15.

How to drive nurses crazy

Some of our colleagues seem to think they can best serve humanity by making life miserable for nurses.* If this was one of the goals that led you to medical school, I suggest careful reading of the following tips to help you succeed in your task.

For attending physicians: When the nurse calls you with new lab data, tell her to call whoever is consulting in the appropriate field and suggest she not bother you. For consultants on the same case: When the nurse calls you with new lab data, scold her and state emphatically that she should have called the attending physician.

Write orders illegibly and leave the floor before the nurse can get to them. When she calls for clarification, have your answering service say you are gone and signed out to another doctor. If you are the other doctor, say you do not know anything about the patient.

Write most of your orders in the metric system but just enough of them in the apothecary system so nurses have to learn both. Let "g" stand for both grain and gram. Do not let your obvious obsolescence bother you.

If you are one of several physicians treating the same patient, do not look at the other doctors' orders before or after you write yours. It is okay if you order one aminoglycoside for a patient already on another. Let the nurse call the other doctors and straighten it out. Your time is much too valuable to spend trying to avoid conflicting orders.

If you plan to be away for a few days, do not tell the head nurse. Let her find out about it when your patient is in respiratory arrest and the answering service is not sure who is covering.

Insist that only you ean order an aspirin or laxative for your patients, but when you put a patient on a ventilator turn the whole thing over to the nurses and respiratory therapists. Tell them not to bother you with the details and to get arterial blood gases whenever they want. Do not confess to them that you have not the slightest idea what the tidal volume should be.

If you are standing next to the chart rack, wait for a nurse to come by and ask her to get your patient's chart for you. If she does, ask her to get you a pen so you can write orders. If she says she is too busy, pout. Then tell everyone the nurses on that floor are no good.

Just as you leave the floor, give one more verbal order that no one quite understands. Then forget the order. When the nurses call for clarification, suggest they pay more attention to you.

Never read nurses' notes but grumble that they never tell you anything.

Criticize nurses vigorously and publicly when they make mistakes. When you err, shrug it off and say that everyone makes mistakes.

Always go to the head of the line in the cafeteria because you have to be in the OR in five minutes. Then take 20 minutes for lunch and dawdle over your coffee for 20 more.

When a nurse calls you at 6:00 a.m. about your patient's deteriorating condition, state firmly that she could have waited until 8:00 a.m. Then come in at 7:30 a.m. and order everything STAT. Question why everything is not ready for you.

After changing the dressing over an infected wound, drop the old dressing on the floor. Do not wash your hands before attending your next patient. Make it clear that hand washing and sterile technique are for others.

If you are not sure whether your patient should be restrained, write the vague order, "Restrain patient PRN." If the family complains that Granny is restrained, say the nurses showed poor judgment. If the family finds Granny on the floor with a broken hip, say the nurses showed poor judgment. Later, explain that "PRN" means the nurse should restrain the patient three minutes before the patient plans to climb over the side rails and break her hip.

Tell your patient she is going home Tuesday but tell the charge nurse you plan to discharge Wednesday. This keeps everyone off guard.

Write surgical prep orders for lumbar spine when you really mean cervical spine. Act betrayed when the patient comes to OR with neck unprepped.

Do not return nurses' telephone calls for orders. You are much too busy. Later, raise a fuss because your patient received no medication for pain.

If the nurses make coffee, help yourself to it but never contribute to the coffee fund. Nurses' incomes are about the same as doctors', so they enjoy providing these small services.

Never carry a dressing tray, for a surgeon's hands are precious. Have the nurse do it.

Never help a nurse reposition a patient in bed; she should be strong enough to do it by herself.

In surgery, if a liter of unexpected and unwanted arterial blood suddenly obscures your operative field, immediately blame the scrub nurse for not

having the proper setup and the circulating nurse for not acting quickly enough to get someone to bail you out. When panic subsides, restrain yourself from thanking them for their help.

If you are hungry and you see a nurse's lunch in the refrigerator, take some of it. She probably had you in mind when she prepared it.

Finally, if your patient's family asks you tell the nurses how much they appreciate the good nursing care, forget to relay the message.

Harvey N. Mandell, M.D.

*I am speaking of sterotypical male physicians who often treat female nurses somewhat differently than they treat male nurses.

Reprinted with permission from *Postgraduate Medicine*, March 1983.

Considering a medical career

I want to be a doctor. Tell me what it is like. How can I know if this is right for me? How can I know if I will be happy as a doctor? Is it hard to earn a living? What do medical schools look for in an applicant, and what courses should I take in college (if I decide to go to medical school) to give me the best chance of being admitted?

Many of us in the medical profession have had these and similar questions put to us by eager and ambitious high school and college students. The most recent person to ask me, because he valued my opinion, was my grandson. After several discussions on this subject he decided medicine was not for him. The answers to the above questions are important to anyone considering a career in medicine, and our replies to the queries of young people with bright and probing minds are not to be given without serious and studied consideration. Inappropriate information, perhaps influenced by personal bias, must be avoided. Undue enthusiasm, reflecting one's own enchantment with and devotion to the practice of medicine, may paint a brighter picture than is warranted. On the other hand, undue pessimism stemming from one's own disenchantment with the problems of the present-day practice of medicine may project a depressing view of a wonderful profession. Young people, with their inquiring minds, their ambition, and their enthusiasm about their future, may be strongly influenced by our words and attitudes. How sad it might be to discourage a potentially fine physician and/or scientist and have him turn to other fields, but how equally distressing to lead a candidate into a profession unsuited to his mind and character or to his goals in life.

In response to an inquiry regarding the best courses to take in preparation for medical school, the student may be astonsihed by advice to limit his scientific courses, and rather to delve heavily into the humanities. A premedical curriculum will demand certain studies in chemistry, physics, and biology, and it behooves the sutdent to excel in these courses, especially chemistry. The medical school curriculum, however, consists almost entirely of scientific subjects; thus the four years of college is the time to become a well rounded, broadly educated person. It is a time to steep oneself in literature, history, arts, languages, philosophy, and economics. It is a special time that will never come again, and time spent on such subjects is of inordinate value. The time should be used to find a good course in the classics, to broaden one's perspective, and to enhance a love of reading and study.

Suppose a father is a physician, as was his father before him. His son respects and loves him, and believes he wishes to follow in his footsteps. How enjoyable it would be to work with and to be taught by that parent. Although outstanding dynasties in the history of medicine are not uncommon, entering medicine only from a sense of obligation, as fulfillment of parental desires and pressures, usually leads to failure. Two of my friends, in order to please their parents but against their own judgment, took the required premedical couses, and were accepted at excellent medical schools. It did not take them long to realize that this was not for them, and they dropped out after only one trimester.

Perhaps financial reward is one of the reasons uppermost in some minds for wanting to become a doctor. "All physicians are wealthy, have fine cars and homes, and take splendid vacations." Nothing could be farther from the truth. The vast majority of doctors, even as their lay counterparts, find it a constant struggle to make financial ends meet. It would be more profitable for one to enter the world of business and finance after college than to struggle through four years of medical school and four to seven subsequent years of postgraduate training before even beginning to earn a livelihood. If one chose to go into business and devote an equivalent amount of energy and an equal number of years learning his work, the businessman's financial status should far surpass anything a doctor might ever earn. The accumulation of wealth can better be achieved in a successful business than in the successful practice of medicine.

One's motives for becoming a doctor may be to acquire respect, admiration, and status among his peers, and also to be highly regarded and recognized

in his own community, his state, and his nation. There was a day when the addition of M.D. to one's name automatically generated respect, reverence, caring and even adulation. The family physician, in his horse and buggy, was loved for his kindness and devotion to his patients. This he could give in quantity, but he could offer little in definitive and curative care. Today, the public judges those in the medical profession with a more critical eye. A colloquialism tells us that "everyone loves his own physician and distrusts all the others." Though an exaggeration, this jest typifies the manner in which doctors are perceived in the lay person's mind. Some few doctors become famous and establish a fine name both at home and abroad, but unfortunately they are rare. I have sadly noted on several occasions that only one year after a patient had a surgical procedure he could no longer even recall his surgeon's name. Obviously, although this surgeon left a scar on the body, he left no lasting impression on the patient's mind. On the positive side, one of the finest rewards for the physician is his acceptance by a peer group with like interests that concentrate on the healing of the ill.

There are young people who consider entering medicine out of a sincer humanitarian desire to help their fellowmen. They may offer this help here in America, or with religious zeal as missionary doctors in distant lands. These are exemplary aspirations, held firmly and honestly by only a small group. It is the exceptional individual who is sustained by such ideals through the long training ordeal to become a missionary doctor. There are few so noble as Dr. Albert Schweitzer. The gratification of aiding in the care of a desperately ill person and seeing a favorable outcome is great, however, and is one of the compensations for failures.

Respect, status, appreciation, the ability to make a comfortable living, gratification through helping others, and being a member of a select group are all rewards of medicine as a career. Do they justify entering the profession? Each attribute contributes in some degree to the magnetism of medicine. All of them added together, however, without a far more important factor, could not have made me happy throughout life as a physician. Scientific interest in the human body, and the human mind, is the exciting and exhilarating force that endures. Paramount is the desire to learn what makes people tick, what physical and chemical processes and reactions enable people to breathe, eat, live, and procreate. The study of the myriad illnesses that overtake people and the ways to combat and at times conquer these illnesses is fascinating. The true physician desires to learn the great discoveries for fighting disease made in both the past and present, and to dream of those to be made in the future. This is what medicine is all about. This interest in the mechanisms of the human body and the ills that befall it, and the manner in which these ills can be overcome, is the challenge. Without this fascination, all the other advantages of being a physician amount to little.

Louis Rosenfeld, M.D.
Nashville, Tennessee

Reprinted with permission from *Southern Medical Journal*, Vol. 78, No. 7, July 1985.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The police report scam"

Kansas City investigators recently have uncovered a new twist to professional patient approaches to physicians and dentists. Following any successful attempt at securing desired prescriptions, a return visit is made within a few days.

The professional patient explains to the prescriber that shortly after his last visit, he was robbed (or burglarized) and his medication was taken. He then shows the physician evidence that he has reported the incident to the police. He usually exhibits a copy of the police report. Obviously, he needs a replacement prescription.

This ploy is apparently very successful. The professional patient has doubled the amount of drugs illegally secured by his original scam.

Caution • Physicians are cautioned to be alert in such occurences. Changing the replacement prescription to an alternative drug — one not so highly valued by the professional patient — can be an effective deterent to this ruse.

The AMA puts current information at your fingertips



The first nationwide medical information network brings a new dimension to the way in which physicians can keep abreast of the latest knowledge in their profession. Through the use of a low-cost computer terminal you can have access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips . . .

DATA BASES:

Drug Information

- Contains up-to-date information on the clinical use of drugs
- More than 1,200 individual drug preparations marketed over some 5,000 trade names
- Can identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions

Excerpta Medica Physicians Information Retrieval and Educational Service

- Index to clinical literature — aids subscribers in locating recent articles and peer reviewed papers that have appeared in more than 300 medical journals worldwide
- Periodicals selected for inclusion in this service cover over 78 specialties and subspecialties
- Helps physicians locate relevant articles quickly and to stay abreast of new developments — saves time

Continuing Medical Education

- Developed by Massachusetts General Hospital in conjunction with the Harvard Medical School
- Allows physicians to earn Category I ACCME credits
- Provides individualized self-paced learning experiences based upon computer simulated patient cases
- Physicians will interact with teaching situation through four predetermined styles: multiple choice, vocabulary, fee text, and tutorial
- Provides confidential means of self-assessment for practicing physicians
- Solutions to problems presented in each teaching scenario can be reviewed and evaluated instantly

Socio-Economic Bibliographic Information

- Guide for locating current articles on the nonclinical aspect of health care
- Includes 4,200 citations from more than 700 health care publications
- Subject areas include economics, education, ethics, international relations, legislation, medical practice, political science, psychology, public health, sociology and statistics
- Convenient ordering of full text reprint of articles directly from the AMA through MED/MAIL

Medical Procedural Coding and Nomenclature

- Provides uniform coding and nomenclature system for reporting medical services and procedures performed by physicians
- Contains 6,000 descriptions of procedures

Disease Information

- Contains descriptions of diseases, disorders and conditions

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION,
PLEASE CONTACT THE
FLORIDA MEDICAL ASSOCIATION, INC.
JACKSONVILLE, FLORIDA
TELEPHONE 904/356-1571

BOOK REVIEWS

Book Review Editor — F. Norman Vickers, M.D.

A woman doctor's Civil War: Esther Hill Hawks diary

Edited by Gerold Schwartz, 301 pages. Price $17.95. University of South Carolina Press.

A few years ago the diaries of Esther Hill Hawks, a nineteenth century New England physician, were discovered in a Massachusetts apartment building about to be renovated. The diary entries describe Hawks' experiences as a teacher for the National Freedman's Relief Association in the Sea Islands of South Carolina and in Florida. The editor, Gerald Schwartz, has carefully identified the military personnel references in Esther Hawks' reminiscences. He has also provided helpful footnotes, a bibliography and a detailed index.

The medical history buff will be disappointed to discover that Dr. Hawks' diary accounts do not relate to the practice of medicine. Instead, they tell the poignant story of her work teaching the Negroes during and after the Civil War. However, the book includes an interesting foreword and afterword that describe the highlights of Esther Hill's life. In 1854 she married Dr. Milton Hawks and became interested in medicine as a result of reading her husband's medical textbooks during their wedding sojourn in Florida. She subsequently studied medicine at the New England Female Medical College and enjoyed a successful practice in Massachusetts after finishing her work with the Freedman's Association. This book will have special appeal to those interested in the history of the Reconstruction and in women's studies.

Elizabeth D. Vickers
Pensacola

- Mrs. Vickers, a former nurse-educator, is the wife of Dr. F. Norman Vickers, Associate Editor of *The Journal*. She is a previous contributor of historical articles to this journal and an avid Pensacola historian.

An illustrated guide to some poisonous plants and animals of Florida

By George R. Campbell, 175 pages. Price $15.95. Pineapple Press, Inc.

As the title implies, this small book is a "handy-dandy" reference manual for quick information and should prove quite useful in the office or emergency room, where this type problem may be encountered. This does not cover all toxic plants and insects and animals, by any means, but certainly the most common forms are covered in this book. The major sections are written more or less in outline form in the poisonous plants section proper, the usual sections of the information given include: common name; where found; scientific names; description of the plants; nature of the toxicity; symptoms caused by exposure to the plant; and the appropriate first aid indicated in countering the effects of the plant.

These data concerning poisonous plants make up the bulk of the book. However, there are sections in the book having to do with toxic insects, toxic fish, toxic reptiles. The same categories of information noted above are usually given for the insects, reptiles, etc., also, and some useful identification data, including sketches, are also included.

This reference book should prove useful in the emergency room or office where such problems arise.

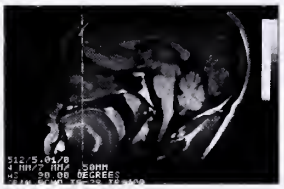
NOTE: Readers who are interested in these subjects should refer to and obtain also a copy of the prize-winning *Journal of the Florida Medical Association* of March, 1978.

L. E. McHenry, M.D.
Melbourne

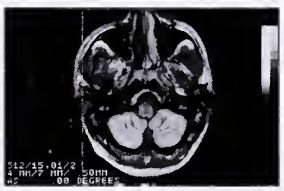
- Dr. McHenry practices pathology in Melbourne and was the Guest Editor of the Special Issue on Adverse Reactions to Plants in Florida, Vol. 65, No. 3, March 1978.

Our new Magnetic Resonance Imaging Center will help you care for her, as no one else can.





MRI utilizes a combination of magnetic and radio frequency fields rather than X-rays.



MRI enables you to see past bone for better clarity of image.

Magnetic resonance imaging is one of the most advanced, most accurate diagnostic tools.

It's also one of the safest. It doesn't use X-rays, so there's no concern about radiation side effects. No contrast media is needed, so there's no discomfort and little chance of allergic reaction.

But there's one thing the MRI Center can offer that few others can. The staff of Miami Children's Hospital. People trained and experienced in the special care and consideration you want for your young patients.

Find out more about our MRI Center. Call us today to arrange for a guided tour or a free brochure at (305) 662-1564. Or use the coupon below.

M·R·I
DIAGNOSTIC CENTER
miami children's hospital



MRI allows you to identify diseases that were previously recognizable only during a surgical procedure.



Multiple images of the human body are available from sagittal, coronal, and axial perspectives.

I'd like to know more about the Magnetic Resonance Imaging Center at Miami Children's Hospital.

☐ Please call me to arrange a tour.
☐ Please send me a free brochure.

Name

Title

Address

Area Code/Telephone

Best Day/Time to Call

Complete and mail to Miami Children's Hospital, 6125 Southwest 31st Street, Miami, FL 33155. Or call (305) 662-1564.

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

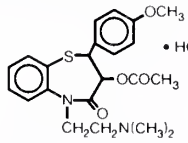
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Marketing membership

The medical auxiliary is a unique organization composed of spouses of physicians who are dedicated to programs that improve the quality of life for all people, promoting health education, and fostering good will among the members of the medical community. Though our members are diverse in their other interests, they share these common goals. These shared aims should form the basis for marketing our membership. The medical auxiliary alone can offer this unique oppotunity for pursuing these objectives. It is the product that fits our requirements for good marketing.

The basis of all good marketing is to analyze the needs and desires of the consumer, and then, to create a product which fits those requirements. Marketing our membership is an ever present task. It is the life-line of our organization: recruiting, retaining, and retrieving members.

Physicians' spouses join the Auxiliary because they perceive its worthwhile objectives. They realize that the Auxiliary needs their own very special talents, and they understand what the Auxiliary can mean to them as individuals and as a potent group for action.

In accomplishing these goals we must remember the importance of communication. Our members and potential members need to be aware of what all levels of the federation — the AMA Auxiliary, the FMA Auxiliary, and the local county auxiliary can achieve. If information is not made available at all levels, how can we know the value of our Auxiliary membership?

We owe our members the opportunity to use their talents. I am constantly amazed at the abilities that are available to us through our Auxilians. It is our responsibility to recognize these gifts and to allow our members to grow through their use. We must emphasize the truth, that their talents and abilities are necessary to reach Auxiliary goals.

We must share our feelings that personally we have received from joining the Auxiliary. Friendship, opportunity for personal growth, feelings of accomplishment, contribution to the improvement of the quality of life for all are but a few of the personal gains and satisfaction of Auxiliary membership.

Our medical schools indicate an increase in female medical students. Are we prepared to be a relevant organization for the male spouse of more than 30% of our potential members? Our foreign-born spouses represent an ever increasing segment of our potential membership. We are obligated to be aware of the special needs of our members who come from different backgrounds, but with the same basic goals. Our resident and medical student spouses are on the verge of the world of private or group practice, or academic medicine. We share the responsibility of making them aware of the support our group offers.

We must find ways to reach the spouses of physicians who do not live in the area of an organized county Auxiliary, and to find ways to meet the needs of more and more of our potential and current members who choose to enter into careers of their own. We must be flexible in our schedules and programming, concise in our meeting format, and a vital force to attract and retain their support.

Let us work together during this year to increase our membership. Let us be the organization, which through our federation has national, state, and local impact. Let us market what we, and we alone, are able to provide — The Medical Auxiliary.

Mrs. David S. (Sandra) Whittaker
FMA Auxiliary First Vice President
Membership Chairman
Ocala

MED TECH '86



PLAN TO ATTEND THE #1 SYMPOSIUM ON THE #2 KILLER—CANCER!

JANUARY 20-22, 1986

CURTIS HIXON CONVENTION CENTER
TAMPA, FLORIDA

Qualifies for 18 Hours Category 1 CME Credit

UNIVERSITY of SOUTH FLORIDA COLLEGE OF MEDICINE 1956 STATE OF FLORIDA — CONTINUING MEDICAL EDUCATION

Featuring

THE 1st ANNUAL H. LEE MOFFITT INTERNATIONAL SYMPOSIUM ON CANCER BIOLOGY AND THERAPEUTICS

SEE AND HEAR INTERNATIONALLY PROMINENT SPEAKERS DISCUSS THE NEWEST DEVELOPMENTS IN CANCER RESEARCH, PREVENTION, DIAGNOSIS AND TREATMENT

MAJOR TOPICS INCLUDE:

- Biochemistry of the Cancer Cell in Selectivity of Drug Action
- Biological and Clinical Implications of the Tumor Cell
- Approaches to the Diagnosis and Treatment of Cancer
- Clinical Advances and Problems in the Treatment of Human Tumors
- Induction, Prevention and Modulation of Cancer
- Immunological Viral Aspects of Neoplasia

SPONSORED BY:

- University of South Florida—College of Medicine
- City of Tampa—
 International Trade Fair Advisory Board
- International Conference Management, Inc.

RESPOND TODAY!!!

CHECK ONE:

_____ Yes, I am interested in MEDTECH '86, please send Attendee Brochure to:

_____ Yes, our company is interested in exhibiting at MEDTECH '86 please send Exhibitor Prospectus to:

PLEASE PRINT:

NAME _____ TITLE _____

INSTITUTION or COMPANY _____

ADDRESS _____

STREET CITY STATE/ZIP

Mail to: **International Conference Management, Inc.** 15851 Dallas Parkway, Suite 1155, Dallas, TX 75248 214/458-7011

G

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where
Southeastern Medical Data Systems
comes in.

Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

Write or call us for additional information and we'll get back to you immediately.

After all, we wouldn't want to try your patience.



southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792

Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

OCTOBER

Treatment Options in Drug and Alcohol Abuse, Oct. 1, Holy Cross Hospital, Ft. Lauderdale. Contact: John Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale, Fl. 33308, (305) 492-5728.

Medicolegal Issues in Obstetrics, Oct. 3-6, New York City, N.Y. For more info: Robert Kruppel, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, (813) 251-3748.

L.W. Blake Memorial CME Conferences, Oct. 4, 11, 18, 25, L.W. Blake Memorial, Bradenton. Contact: Jack H. Sanders, M.D., 2010 59th Street, West #5100, Bradenton, FL 33529.

The Professional and Chemical Dependency, Oct. 4, New World Landing, Pensacola. Contact: Brunie Emanuel, Route 2, Box 174, Gulf Breeze, Florida 32561, 932-9375.

Management of the Crooked Nose, Oct. 5, Mt. Sinai Medical Center/Carollwood Community Center, Miami Beach/Tampa. Contact: EF Teleplast, Registrar, (312) 856-1818.

Temporomadinibular Joint (JMJ), October 8, Doctors Hospital, Lake Worth. Contact: Roberto Miguel, M.D., 2889 10th Avenue North, #203, Lake Worth, Fl. 33461, (305) 965-3280.

Laser Surgery Training Course, Oct. 8-11, Contemporary Resort Hotel, Orlando. Contact: Douglas Dew, M.D., 1414 S. Kuhl Avenue, Orlando, Fl., 32806, (305) 841-5144.

1985 Fall Conference on Pediatric Trauma, Oct. 11-12, Orlando Airport Marriott, Orlando. Contact: Joan H. Pyle, Dept. of EMS, P.O. Box 1393, Orlando, Fl. 32802, (305) 420-3188.

Vascular and Pulmonary Diseases — Diagnosis and Managment, Oct. 11-13, Dutch Americana Hotel, Lake Buena Vista. Contact: Stephen E. Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (3)3) 798-9682.

1985 TNO-ISIR Meeting on the Interferon System, Oct. 13-18, Holiday Inn, Surfside, Clearwater. Contact: William Stewart, 12901 N. 30th Street, Tampa, Fl. 33612, 813-974-2178.

Eleventh Annual PanAmerican Seminar, Oct. 14-18, Mount Sinai Medical Center, Miami Beach. For more info: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Calcium Channel Blockers New Concepts, Oct. 16, Lincoln Hotel, Tampa. Contact: Stephen Glasser, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 974-2880.

Advanced Neuroradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

First Annual Conference on Clinical Problems in Primary Care, Oct. 18, USF College of Medicine, Tampa. Contact: Joseph Finster, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 974-4296.

Selected Topics in Internal Medicine, Oct. 18-19, New World Landing, Pensacola. Contact: K. Inge Holmar, 14 W. Jordan Street, Pensacola, FL 32501, (904) 434-0151.

Third Annual Meeting of the Vitreous Society, October 23-26, Contemporary Hotel, Lake Buena Vista. Contact: W.S. Grizzard, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, 813-875-6373.

Pain Management Conference, Oct. 24-26, Royal Plaza Hotel, Orlando. Contact: Marge Duchano, R.N., Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando, Fl. 32806, (305) 841-5144.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Fall 1985 Family Practice Review, Oct. 28-Nov. 1, Palace Hotel, Lake Buena Vista. For information: Lamar Crevasse, M.D., JHMHC J-233, Gainesville, 32610, (904) 392-3143.

Clnical Applications for Pulsed, Continuous Color Flow Doppler Echocardiography, Oct.31-Nov. 1, Mount Sinai Medical Center, Miami Beach. For information: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., 12901 N. 30th Street, Box 15, Tampa 33612, 813-974-4214.

11th Annual S.E. Conference on High Blood Pressure, Oct. 30-Nov. 1, Las Palmas Inn, Orlando. Contact: James C. Bailey, 1317 Winewood Blvd., Tallahassee, Fl. 32301, (904) 488-2901.

NOVEMBER

Twenty-sixth Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Hotel, Clearwater. For information: Henry Marriott, M.D., 601 12th Street N., St. Petersburg 33705, (813) 894-0790.

Advanced Cardiac Life Support, Nov. 2-3, USF College of Medicine, Tampa. For more information: J. Paul Michlin, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 251-6911.

Spinal Deformities, November 3-6, Sheraton Bal Harbour, Bal Harbour. For information: Barry Silverman, 2050 N.E. 163rd Street, N. Miami Beach 33162, (305) 944-4746.

Current Advances in Perinatology, Nov. 3-9, Virgin Islands. Contact: Charles R. Bauer, M.D., Division of Pediatrics, P.O. Box 016960, Miami, Fl. 33101, (305) 547-5808.

Third Annual Meeting Florida Medical Professional Group, Nov. 8-10, Tradewinds Hotel, St. Petersburg. Contact: Walter W. Hamilton, 1201 5th Avenue North #505, St. Petersburg, FL (813) 821-9760.

Eleventh Annual Review Courses in OB/GYN, Nov. 13, Miami. Contact: Patty Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Third Annual Childrens Hospital Foundation — Care of the Sick Child, Nov. 14-16, Palace Hotel, Lake Buena Vista. Contact: Joseph Chiaro, M.D., 1414 S. Kuhl Ave. Orlando, Fl. 32806, (305) 841-5143.

Eleventh Annual OB/GYN Reveiw Courses, Nov. 14-25, Sheraton Royal Biscayne Hotel, Key Biscayne. Contact: Patti Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Ninth Annual Seminar: Evolution in the Total Care of the Pediatric Hematology/Oncology Patient, November 21-23, Hyatt Orlando, Orlando. For information: Cindi Butson, P.O. Box 13372, University Station, Gainesville 32604, 904-375-6848.

Vascular and Pulmonary Diseases: Diagonsis and Management, Nov. 22-24, Sonesta Beach Hotel, Key Biscayne. Contact: Stephen E. Mattingly, 5808 S. Rapp Street, Littleton, Co 80120, (303) 798-9682.

DECEMBER

Techniques of Therapeutic Gastrointestinal Endoscopy, December 4-6, Contemporary Resort Hotel, Lake Buena Vista. For info: H. Worth Boyce Jr., M.D., USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612 (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation II: Technology and Techniques, Dec. 4-8, Sheraton Bal Harbour, Miami. Contact: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, (305) 547-6716.

Clinical Allergy and Immunology for the Practicing Physician, Dec. 5-7, Palace Hotel, Lake Buena Vista. For info: Richard F. Lockey, M.D., VA Hospital, 13000 N. 30th St., Tampa, 33612, (813) 972-2000, ext.596.

Ear, Nose, & Throat Diseases in Children, December 7-11, The Breakers, Palm Beach. For information: 125 DeSoto Street, Piladelphia, PA 15213, 412-647-5466.

Emergencies in Internal Medicine, VIII, Dec. 8-14, St. Thomas, Virgin Islands. For more information: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, 305-547-6716.

New Approaches to Common Disorders II, Dec. 11-14, Clearwater Beach. For information: Joel Gleason, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 397-5511.

JANUARY

Thirty-first Annual Cardiovascular Seminar, Jan. 10-11, Sheraton Sand Key Resort, Clearwater Beach. Contact: Anita Godsey, P.O. Box 7188, St. Petersburg, FL 33734, (813) 526-6000.

Omni-Specialty Medical Update, Jan. 12-14, Naples Bath and Tennis Club, Naples. Contact: James Marion, M.D.

The Economic Impact: Drug Abuse in the Work Force, Jan. 15-17, James L. Knight International Club, Miami. Contact: Conference Center, 400 S.E. 2nd Avenue, Miami, FL 33131, (305) 372-0140.

Eighteenth Annual Postgraduate Seminar in Pediatric and Adulat Urology, Jan. 15-18, Sheraton Bal Habor, Miami Beach. Contact: Victor A. Poktano, M.D., Dept. of Urology, 6614 Miami Lakes Drive East, Miami Lakes, FL 32014, (305) 687-1367.

Cardiology Tutorials in the Wilderness, Jan. 18-25, Canoe Trip, Everglades. Contact: Peter E. Pool, M.D., UCSD School of Medicine, La Jolla, CA 92093, (619) 452-3940.

Eleventh Annual Review and Recent Practical Advantages in Pathology, Jan. 19-24, Hyatt Hotel, Miami. Contact: A. Morales, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6437.

Symposium on Cancer Biology and Therapeutics, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: J. G. Cory, Ph.D., Medical Center, Box 46, 12901 N. 30th Street, Tampa, FL 33612.

MedTech '86, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: International Conference Management, c/o The Madison, 15851 Dallas Parkway, Suite 1155, Dallas, TX 75248, (214) 458-7011.

Annual Symposium on Cancer Biology and Therapeutics, Jan. 20-22, USF College of Medicine, Tampa. Contact: Joseph Cory, Ph.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

A Practical Approach to Solutions and Problems in Burn Care, Jan. 30-Feb 1, Clearwater Beach. Contact: C. Wayne Cruse, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

Vascular and Pulmonary Diseases: Diagnosis and Management, Jan. 31-Feb. 2, Don Cesar Hotel, St. Petersburg. Contact: Stephen E. Mattingly, (303) 798-9682.

FEBRUARY

Ultrasound Integrated into Modern Ob-Gyn, Miami Beach. Contact: William A. Little, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6944.

Internal Medicine — Selected Aspects, Feb. 1-8, Telluride, Colorado. Contact: Gloria Allington, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Twelfth Annual Bail Conference in Anesthesiology, Vail, Colorado. Contact: Brian Craythorne, M.D., P.O. Box 016960, Miami, FL 33101, (305) 547-6411.

Controversies in Carcinoma of the Breast, Feb. 1-8, Snowmass, Colorado. Contact: Martin Silbiger, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-2538.

Eighteenth Miami Winter Symposium — Advances in Gene Technology, Feb. 3-7, Hyatt Regency Hotel, Miami. Contact: William J. Whelan, P.O. Box 016960, Miami, FL 33101, (305) 547-6265.

Hair Replacement Surgery for the Beginner, Feb. 5-9, Miami Airport Hilton, Miami. Contact: Sorrel S. Risnik, M.D., 9065 S.W. 87 Ave., Suite 109, Miami, FL 33176, (305) 279-6060.

Twenty-third Annual Neuro-ophthalmology Course, Feb. 6-8, Sonesta Beach Hotel, Key Biscayne. Contact: Hilary Hose, 6125 S.W. 31 Street, Miami, FL 33155, (305) 667-7060.

Pulmonary, Allergy and Infectious Diseases, Feb. 10-14, Palace Hotel, Lake Buena Vista. Contact: Udaya Prakash, M.D., 200 1st Street, S.W., Rochester, MN 55905, (507) 284-2511.

Pediatrics for the Practitioner, Feb. 14, USF College of Medicine, Tampa. Contact: Herbert Pomerance, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4214.

Conference on the Beach, Feb. 17-22, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., P.O. Box 1990, Daytona Beach, FL 32015, (904) 254-4051.

Pediatric Dermatology Seminar, Feb. 20-23, Eden Roc Hotel, Miami Beach. Contact: Guenter Kahn, 16800 N.W. 2nd Avenue #401, N. Miami Beach, FL 33169, (305) 652-8600.

Eleventh Annual Midwinter Seminar in Ob/Gyn, Feb. 26-March 1, St. Petersburg Beach. Contact: J. M. Ungram, M.D., 12901 N. 30th Street, Tampa, FL 33617, (813) 974-2088.

Eighteenth Teaching Conference in Clinical Cardiology, Feb. 26-March 1, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., D-41, P.O. Box 016960, Miami, FL 33101, (305) 547-6491.

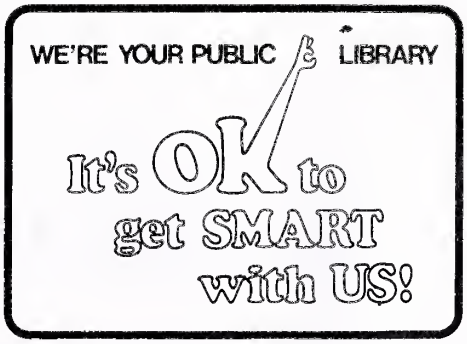
Health Care of the Elderly, Feb. 27-March 1, USF College of Medicine, Tampa. Contact: Eric Pfeiffer, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4355.

Current Concepts in Surgery of the Gastrointestinal Tract, Feb. 27-March 1, Diplomat Hotel, Hollywood. Contact: 6614 Miami Lakes Drive East, Miami Lakes, FL 33014, (305) 687-1367.

Surgical Anatomy of the Eyelids, Orbit and Lacrimal Apparatus, Feb. 27-March 1, Lincoln Hotel and USF College of Medicine, Tampa. Contact: Jay J. Older, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-3170.

ONGOING

Seminars — Most major ski areas, Club Med, Disney World and other resorts. Topic: Medical/Legal and Financial Management. Accredited. Current Concept Seminars, Inc. (since 1980) 3301 Johnson St., Hollywood, FL 33021 (800) 428-6069. Fee $175.



THE CHANGING PRACTICE OF MEDICINE

The changes are all around us. New HMO's. Increasing numbers of medical school graduates. Pyramiding patient insurance headaches. Lack of dedicated personnel. Increasing malpractice suits and premiums.

This is a special invitation for you to Aim High as a member of the Air Force Health Care Team.

One of the advantages you would enjoy with us is time. Time for your patients. Time to keep professionally current. Time to relax. 30 days of vacation with pay each year.

Another advantage is peace of mind—financial security now, and a generous retirement if you qualify.

Leave the administrative hassles to others. Find out about an Air Force practice by calling me in complete confidence.

Major Ron Bailey
(305) 494-2728

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

PRIMARY CARE FACILITY in West Palm Beach seeking part time physicians for hourly work, and full time positions for future facilities. Send CV to: Administrator, P.O. Box 25986, Tamarac, FL 33320.

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

EMERGENCY PHYSICIANS — Facility in Bradenton, Florida seeks Emergency Room Physician with minimum 3 years full time experience. Must be Board Certified in a primary care specialty, (IM, FP, GS, EM). Excellent remuneration. For further information contact Jodi Berk, toll free 1-800-645-4848.

GENERAL INTERNISTS, PEDIATRICIANS, NEUROLOGISTS, ENT, THORACIC AND GENERAL SURGERY: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

EXPERIENCED, BOARD CERTIFIED SPECIALISTS in orthopedics, neurosurgery/neurology, and EMG wanted for part time association with office based group performing medico-legal evaluations in Dade and Broward Counties. We offer excellent renumeration with no nights or weekends on call, and minimal malpractice exposure. Call (305) 557-0900 or send C.V. to Medical Director, Southern Diagnostic Associates, Inc., 1575 West 49th Street, Suite 132, Hialeah, Florida 33012.

FAMILY PHYSICIAN to join busy internist in the Florida Keys. Office has laboratory, EKG and X-ray capabilities. Flexible association available. University training preferred. Send CV: Medical Clinic, P.O. Box 2008F, Key West, FL 33040.

PSYCHIATRIST — full-time position open for board certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient only. Florida license needed. Write or call: A. Mullin, M.D., Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Avenue, Jacksonville, FL 32204, Phone (904) 384-2364.

MEDICAL EXECUTIVE DIRECTOR (psychiatrist) — Exciting opportunity for an innovative psychiatrist to direct a 32-bed psychiatric hospital for adults and adolescents. Hospital corporation is part of a highly regarded, comprehensive system of mental health programs serving Tampa, a beautiful and booming "Megatrend" city on Florida's west coast. New hospital to be built in 1986. The Medical Executive Director will recruit additional psychiatrists to round out the existing multi-disciplinary team and will be responsible for inpatient treatment programs. This person will also serve as Director of Psychiatric Services for outpatient programs in affiliated corporations. Possibility of affiliation with University of South Florida and opportunities for corporate and industrial consultation if desired. Qualifications: Board certified/eligible, excellent clinical and administrative abilities, and eligibility for Florida medical license. Put your creative clinical and managerial ideas to work! Salary competitive. Write or call Dr. Anthony Broskowski, NORTHSIDE, 13301 North 30th Street, Tampa, FL 33612, (813) 971-0192.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

FAMILY PHYSICIAN TO JOIN busy internist in Florida Keys. Office has laboratory, EKG and X-ray capabilities. Will provide very flexible association to the right individual. Send CV to: Robert Carraway, M.D., P.O. Box 2008, Key West, FL 33040 (305) 294-0511.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPAEDIC SURGEON — wanted to join an established surgeon, southeast Florida, Boynton Beach area. Send CV: C-1279, P.O. Box 2411, Jacksonville, Fl. 32203.

FAMILY PRACTIONER: Immediate opening for primary care physician seeking a challenge. Expanding 153-bed acute care hospital in Correctional setting offers professional growth opportunities. If interested in more hands-on patient care, please call Dr. John E. Metheny at (904) 496-2222 (ext. 121) or send CV to: Personnel Office, Reception and Medical Center, P.O. Box 628, Lake Butler, Fl. 32054-0628.

MEDICAL EXECUTIVE DIRECTOR needed for the Office of Disability Determinations. Assists in policy guidance and oversees medical evaluations. No patient contact. Previous administrative and/or medical disability program experience desirable. Florida license required. Equal Opportunity Employer. Salary: $51,991.20 to $91,851.12. Contact Robert Rumbley, PR Coordinator, Disability Determinations, HRS, 2600 Blairstone Road, Tallahassee, Fl. 32301 (904-488-6369).

WANTED: CARDIOLOGIST for Palm Beach County/Delray Beach area — immediate opening in active medical center. Early opportunity to join firm. Call Irv Herman, 305-499-5252, or write C-1281, P.O. Box 2411, Jacksonville, Fl. 32203.

EMERGENCY PHYSICIAN needed for independant group at new Gulf-coast hospital. Expected income over $100,000. Send CV to C-1285, P.O. Box 2411, Jacksonville, Fl. 32203.

FAMILY PRACTICE OR EMERGENCY MEDICINE physician needed for established walk-in clinic in Tallahassee. Call Jay Maggiore, M.D., (904) 234-8492.

FAMILY PHYSICIANS for Family Practice Acute Care Wellness and Sports Center, Integrated Jacksonville's best beach area. An unusual situation. Join three certified family phys., nutritionist, psychologist, exercise physiologist, phypsical therapist, in practicing the ultimate in family medicine. Uniquely integrated program of acute care, family practice, and

total health care. Physicians who join us will have options of becoming a part of management quickly. Stable population, little tourism, and a great place to live at the ocean. Leisure life style. Twelve minutes from Jacksonville. Lots of time off. Cont. ed. is a requirement. Any residency-trained family physician would be proud to be associated with this practice. Practice is 3 years old. Contact. L.E. (Bruno) Masters, M.D., 100 Royal Palm Dr., Atlantic Beach, Fl. 32233, or call collect, (904) 241-5107.

FULL-TIME opportunity available for well trained physician to direct Emergency Services Department in 200 bed, accredited acute care facility. Responsibilities include recruitment of Emergency Service trained physicians. Send letter of interest and curriculum vitae to Box C-1292, P.O. Box 2411, Jacksonville, FL 32203.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

PLASTIC SURGEONS — Excellent opportunity for Board Eligible/Certified surgeons for professionally and financially rewarding practice opportunities in various Florida locations. Reply to C-1284, Box P.O. 2411, Jacksonville, Fl. 32203.

ORLANDO: Active 4 man ob-gyn practice seeks association with motivated compassionte BE/BC ob-gyn leading to partnership. Affiliated with large rapidly expanding referal center. The community is young and thriving. Send CV to The Ob-Gyn Group, 2905 McRae Ave., Orlando, Fl. 32803, Attn: Howard Schechter, M.D., 305-898-7151.

ASSISTANT PROFESSOR: Tenure accruing position in the Department of Pathology, College of Medicine, University of Florida. Candidate must have a Ph.D. degree and at least 5 years of research experience is desirable with a strong record of scholarly achievement and significant research contributions in avian oncogenes and avian retroviruses. Candidates should be experienced in research related to molecular biology of cancer. Major interest in hemopoiesis and cell differentiation is desirable. Recruiting deadline is 10/15/85 with an anticipated starting date of 11/1/85. Salary is compatible to experience. Interested candidates should forward applicatins to Ammon B. Peck, Ph.D., Associate Professor, Pathology, Box J-275, College of Medicine, Gainesville, FL 32610. Equal Opportunity Employment/Affirmative Action Employer.

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

COME TO PARADISE: Rewarding primary care practice in Key West, Florida. Join the Island Clinic Group. Phone 305-294-4657. Ask for John Buckner.

FAMILY PHYSICIAN, Board certified, to join a well established solo practice in Central Florida. Initial salary with early opportunity for partnership. For further information, please call (813) 859-2748.

WORKING MEDICAL DIRECTOR wanted for outpatient walk-in center. Private practice opportunity on Florida Gulf Coast. Available immediately. Financial renumeration based on % of gross receipts. Respond with resume including phone number to Medical Clinic, P.O. Box 25312, Tampa, Fl 33622.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only. C-1289, P.O. Box 2411, Jacksonville, FL 32203

NEUROLOGIST, Board certified or eligible to join a solo practice in a rapidly growing community located in Florida sunbelt. Full EP, EMG, EEG and CT facilities. Plan to expand services. Early full partnership. Reply with CV to Box C-1294, P.O. Box 2411, Jacksonville, FL 32203.

WE ARE INVITING a physician with a career orientation in Industrial, Emergency, and/or Family Medicine to explore a mutually rewarding association with a South Florida facility. Excellent compensation package. Write C-1295, P.O. Box 2411, Jacksonville, FL 32203.

EMERGENCY DEPARTMENT DIRECTOR: Position available at large regional medical center, Treasure Coast area. Full specialty back up and committment to departmental development. Candidates should be career oriented and have demonstrated leadership ability. Excellent compensation with paid malpractice and group health insurance. Call or send C.V. to: Emergicare, Inc., 635 East Main Street, Hendersonville, Tennessee 37075, (615) 824-1184.

PRACTICE OPPORTUNITY for family physician, in one of nations most rapidly growing areas. Located adjacent to busy ambulatory care center that would be a continuous referral source. Contact: Martin Cunningham, M.D., 1111 NE 25th Ave., Suite 302, Ocala, FL 32670.

FAMILY PRACTICE opportunity in Tampa. Excellent opportunity for a board certified or board eligible family practitioner to join a well-established expanding practice. Guaranteed salary with strong incentives. Send C.V. to Box C-1297, P.O. Box 2411, Jacksonville, FL 32203.

CARDIOLOGIST seeks associate to join him in active invasive and non-invasive practice in South Miami area. Position available immediately. Send CV to David Wells, M.D., 6280 Sunset Drive, Suite 604, Miami, FL 33143, (303) 665-8500.

A VENTURE IN INDIA — a corporate organization is undertaking a modern laboratory project in Bangalore. Possible expansion into a hospital. Unlimited growth potential. Full repartiation of profits and tax deductible travels to India. For details contact — Arun Yesupriua, M.D., Call 914-235-6891 or 718-699-1505.

EMERGENCY AND PRIMARY CARE physician: we are looking for a career-oriented physician to join our established and expanding group which includes two ambulatory care facilities. Equity participation available. Send CV in confidence to SRM & Associates, Inc., 1239 Hillsboro Mile #407, Hillsboro Beach, FL 33062.

WALK-IN CLINIC, Tampa, needs M.D.'s, 70k and up. CV to FMD, 7740 Starkey Road, Seminole, FL 33543.

GENERAL-VASCULAR Surgeon needed to join same in busy private practice. Two modern hospitals (250 and 700 beds). Vasc. Lab. Lovely sub-tropical Florida Gulf Coast. All sports and cultural activities nearby. Send CV to: Barry N. Haicken, M.D., 1258 West Bay Drive, Largo, FL 33540.

TREASURE COAST AREA, Ft. Pierce, Port St. Lucie: Immediate openings for physicians to work with established multi-location, hospital based Emergency Department group. Salary range from $65,000 to $95,000, with paid malpractice and group haelth insurance. Flexible schedule, with full specialty back-up, excellent working conditions; call or send CV to Emergicare, Inc., 635 East Main Street, Hendersonville, Tennessee 37075; (615) 824-1184.

ORTHOPAEDIC SURGEON — South Florida. Busy three-man group. Quality care emphasized. Practice includes trauma, reconstructive, arthroscope and hand surgery. Send CV to: H. Reitman, M.D., R. Kleiman, M.D., B. Berkowitz, M.D., 150 N.W. 70th Avenue, Suite 3, Plantation, FL 33317, (305)735-6160.

PATHOLOGIST: full-time position for Board certified or eligible pathologists to join two pathologists in Florida West Coast multispecialty group. Entry level position offering security with good prospects. C-1296, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST, BC/BE to join busy solo internist in Orlando. Rapidly growing area. Great lifestyle. Good coverage schedule. Contact: Dr. Buswell-Charkow, 422 N. Dillard St., Winter Garden, FL 32787.

EMERGENCY MEDICINE: Practice in beautiful Palm Beach County. Physicians needed for new group staffing two hospitals. Full or part time. Prefer BE or BC but will consider if experienced. Excellent compensation and malpractice insurance. Contact with CV: Medical Director, P.O. Box 273503, Boca Raton, Fl., 33427.

Situations Wanted

LOCUM-TENENS: Radiologist, Board Certified, 53, academic and administrative experience, does most modalities, will also consider permanent association. Please write Box C-1265, P.O. Box 2411, Jacksonville, Fl. 32203.

BOARD CERTIFIED PEDIATRICIAN, Florida licensed, seeks group practice in Florida. C-1227, P.O. Box 2411, Jacksonville, Fl 32203.

M.D. ANST, BC seeking a position, locum tenens, however sharing a full-time with a colleague is most desirable. Experienced ER physician, active ACLS, in the process of taking the ABEM seeking a position in moderate vol ER with some trauma. C-1288, P.O. Box 2411, Jacksonville, Fl. 32203.

PEDIATRICIAN, B/E, U.S. trained, Florida licensed. Has completed one year of Pedi Heme lone fellowship. Looking for general pediatrics opportunity in South Florida. Will join solo practitioner or group. Helen Mitchell, M.D., 840 Madrid St., Miami, Fl. 33134, 305-447-0486.

VASCULAR GENERAL SURGEON. Vascular surgery fellowship. Board Certified. Four years private practice, desires multi-specialty group practice. C-1282, P.O. Box 2411, Jacksonville, Fl. 32203.

RADIOLOGIST, ABR, excellent qualifications, all modalities, presently staff in major West Coast teaching center, seeks quality practice position. Consider initial part-time or locum arrangement. C-1283, P.O. Box 2411, Jacksonville, FL 32203.

AMERICAN BOARD OF EMERGENCY MEDICINE, certified. Seeking position full time or part time in Palm Beach or Broward County. Six years experience as Director of a Department in a 250 bed hospital. ACLS and ATLS. Will consider also administrative position with private organization. Please contact M.D. 22751 Pinewood Court, Boca Raton, Fl. 33433.

PULMONOLOGIST: Fellow College of Chest Physicians, License: Conn., Mass. Resigned position of senior physician, Holley State Hospital, Florida. Age 75 years. Seek Administrative job. Call (305) 585-2832. Write 3460 S. Ocean Blvd., Palm Beach, Florida 33480.

PSYCHIATRIST, bd. certified, university trained, lic. Ohio, Indiana, Illinois (but not planning to sit for Fl license) seeks employment in Florida — in a position where Florida license would not be required. Available 1/1/86. Reply to Box C-1293, P.O. Box 2411, Jacksonville, FL 32203.

PATHOLOGIST, Florida licensed, AP/CP 1985. Fellowship in AP interest in fine needle aspiration. Available November-December 1985. Desire position as a general pathologist anywhere in Florida. Reply: Susanna Kunis, M.D., 521 Howard Ave., Altamonte Springs, FL 32701, (305) 834-8122 (home) or (305) 841-5219 (work).

NEURORADIOLOGIST: Board certified, 2 year University Fellowship, expertise in pediatric and adult CT, angio, myelo and DSA, also excellent skills in general diagnostic as partner for last 2 years in large multispecialty group. Thirty-five year old, married, one child. President, University of Florida graduating class 1978, who wishes to return home. Lawrence H. Schott, M.D., 1818 Lenard St., Wausau, Wisconsin 54401, (715) 675-9900 evenings.

PLASTIC AND RECONSTRUCTIVE SURGEON. Recently completed residency, board eligible. Seeking any practice situation; solo, group, partnership etc. prefer Florida's Southeast Coast, especially Palm Beach County. Immediately available with Florida license. Reply: Alan A. Yurkiewicz, M.D., 32 Hobart Dr., Apt. C4, Newark, Delaware, 19713. Phone (302) 737-7071.

INTERNIST with subspecialty training in noninvasive cardiology,seeks to purchase or associate with, practice in South Florida. Reply C-1184, P.O. Box 2411, Jacksonville, FL 32203.

Practices Available

INTERNAL-MED, FAMILY Practice est. 30 years for sale. Eager to retire. No reasonable offer refused. No cash needed for physician just completing residency. Five local hospitals require Board Eligible. Write Medical Center, P.O. Box 7603, West Palm Beach, FL 33405.

INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: DERMATOLOGIC PRACTICE. Fully-equipped and beautifully furnished offices in prestigious building. Ideally located in West Palm Beach, Fl. Could stay on one year or longer to assist in turnover. Great opportunity. Reply C-1287, P.O. Box 2411, Jacksonville, Fl. 32203.

FAMILY PRACTICE available, 30 minutes from Gainesville, 50 minutes from Jacksonville, Fl. With all equipment. 904-964-6701.

THIRTY-YEAR Family Practice grossing $140,000. 4-day week. 2,000 ft. Equipped office Lease-purchase. On lake. Fish ocean, river, savannahs. Boat any direction. Box 37, Jensen Beach, FL 33457.

D.O. WITH 9 YEARS EMERGENCY ROOM EXPERIENCE seeking position in urgent care center or E.R. in S.E. Florida Keys. Reply C-1286, P.O. Box 2411, Jacksonville, Fl. 32203 or call (616) 845-7620.

Real Estate

DECORATED OFFICE SPACE AVAILABLE in the beautiful Lighthouse Point Professional Building at 2211 NE 36 Street, Lighthouse Point, Florida. For details please call (305) 942-1444.

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

FOR LEASE, 1,500 square ft. Medical office, ideal location, Douglas Road in Altamonte Springs and North Orlando. Mini blinds and cabinets, reasonable rent, immediate occupancy. Phone (305) 862-0107.

SHARE MEDICAL OFFICE, Fully equipped with stress test, holter monitor, x-ray and laboratory equipment for internist or medical sub-specialist. Sarasota/Venice/Nokomis area. B.J. Ross, Office Manager, 3231 Gulf Gate Drive, Sarasota, FL 3358 (813) 924-1193.

FOR RENT — JACKSONVILLE — Office space patially furnished in Dillon Building next to St. Vincents Hospital. 1265 sp. ft. now being used by two active physicians planning to relocate. Available January 1, 1986 or earlier. Call (904) 388-2678.

WITHLACOOCHEE RIVERFRONT: Custom Cedar Home on 2 heavily wooded acres, 2 Br/2½ baths, massive stone fireplace, Jenn-Aire Grill, huge deck and dock, direct Gulf access, send for Pkg.-Price. Reduced to $169,900. Lona Lubin — Realtor Assoc. The Corey Co., 423 Corey Ave., St. Petersburg Beach, FL 33706 (813) 367-4561.

PHYSICIAN'S OFFICE and home adjoining — available for purchase. Located off Coral Way in Miami. Rare opportunity for residency office combined on one property. Contact: Richard Klass, 1320 S. Dixie Highway, Miami, FL 33146.

SHARE MEDICAL-SURGICAL OFFICE, 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441. Three exam rooms, lab, and business office. Patrick E. Callaghan, M.D., (305) 428-2420.

TALLAHASSEE: FOR RENT. — Fully furnished office presently used as a dermatological practice. In beautiful medical park across street from new rehabilitation hospital and mid-way between two large hospitals. Call 904-877-3129 or 893-1385.

FOR RENT — Medical office suite in Vero Beach, FL; aproximately 3,000 square ft., excellent parking, attractive, sound brick building. Five year lease offered at $3,500 per month. Located on waterfront, 30 Royal Palm Blvd. — perfect for primary care physicians, family practice, or walk-in clinic. Call (305) 562-7922 and ask for Bruce MacIntyre. 701 Shore Dr., Vero Beach, FL 32963.

PRIME MEDICAL OFFICE Space for rent. Reasonable, near new hospital. Zephyrhlls, FL. For information, please call (813) 782-4505.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned medical instrumentation: EKG, Lab, Holter, scanners, 2 D. Echos, stress-test, etc. Contact: Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065, 305-972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write: Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2, Box 386 A, Adel, Georgia. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

HOLTER SCANNING AND INTERPRETATION nationwide. For offices or hospitals at very special rates. Includes cardiology interpretation, immediate phone reporting, etc. Special rates for hospitals, HMO's. Will provide recorder and arrange for your office to learn patient connection, quality, etc. For information call Pittsburgh Cardiovascular, (412) 372-2035. 2550 Mosside Boulevard, Monroeville, PA 15146.

MEDICAL MARKETING section of the Florida Freelance Writers Assn. offers comprehensive services in writing, printing, advertising and publicity by professionals in all areas of Florida. For information and free estimates call (305) 274-0999 or write Larry Strum, FFWA, 11550 SW 82 Terrace, Miami 33173, member American Marketing and American Medical Writing Writers Assns.

Equipment

CLAY-ADAMS QEA Sodium Potassium instrument. $2,000 used. Call (305) 776-1950.

COMPLETE RADIOGRAPHIC and Fluoroscopic X-ray room with 10 y.o. Picker 90/15 table. Mirror optics and precise optics T.V. system included. The image intensifer, fluoroscopic x-ray tube and automatic brightness system are only one year old. Call Kissimmee Memorial Hosp. (305) 846-4343, Ext. 387 for Dr. Sessions or Dr. Mayo.

FOR SALE: X-Ray equipment, Xonics Radiographic Room Control Table Tube Stand and AFP 14 XL Processor and other misc. equipment. Contact Dr. Steven Moss, 13910 Fivay Road, Hudson, FL 33567.

Meetings

WEEKLY SEMINARS. Most major ski areas, Club Med, Disney World, Cruising aboard sailboats in the Virgin Islands or a Mississippi Paddlewheeler. Topic: Medical-Legal Issues., Accredited. Current Concept Seminars, Inc. (since 1980). 3301 Johnson St., Hollywood, FL 33021, (800) 428-6069. $175.

American Diabetes Association

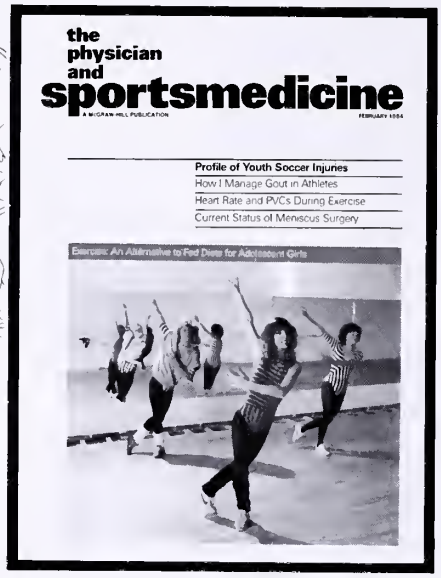
The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.

CALL TODAY!

Florida Affiliate
(305) 894-6664

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

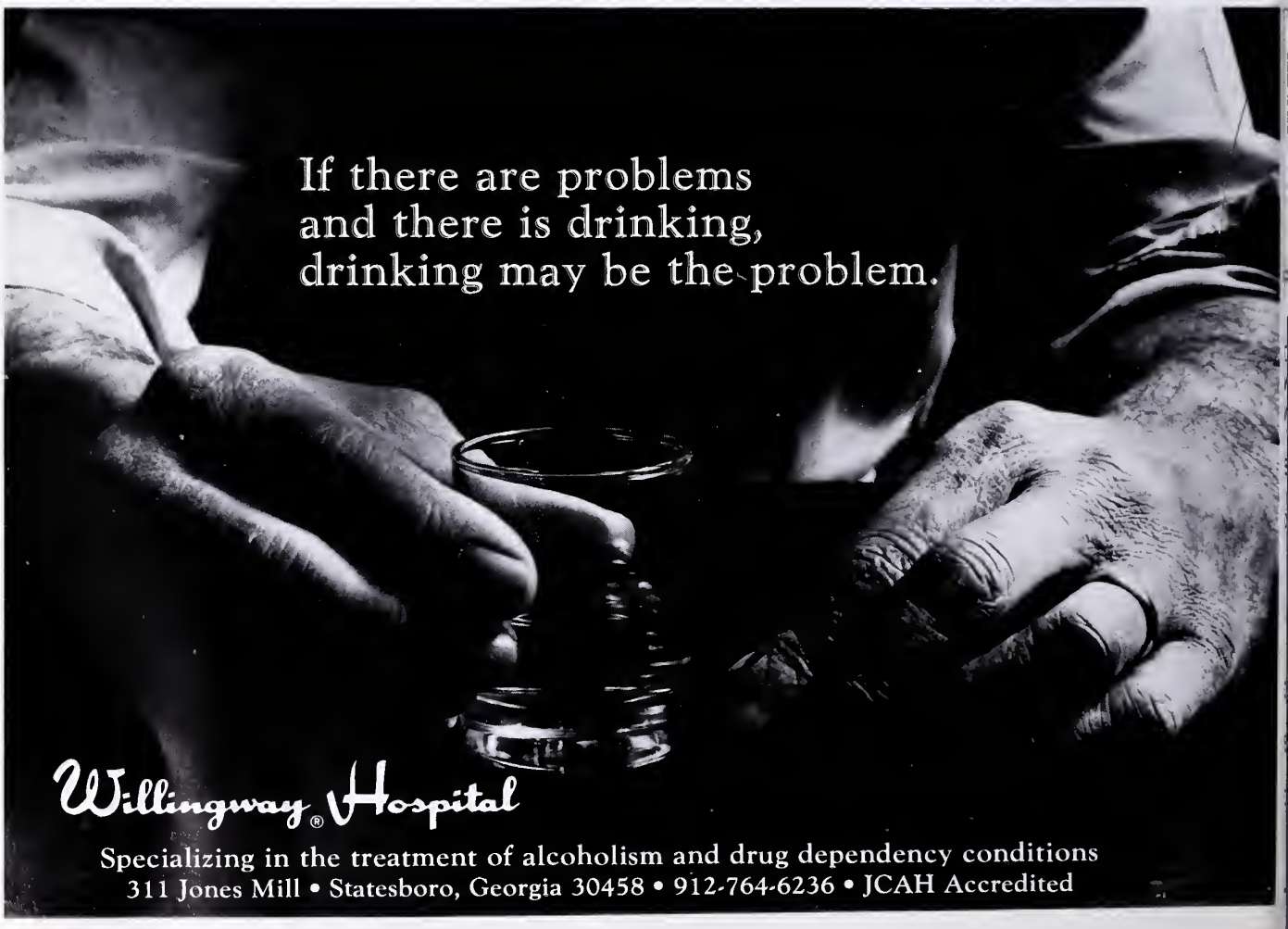
Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

AMC Graw Hill



THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

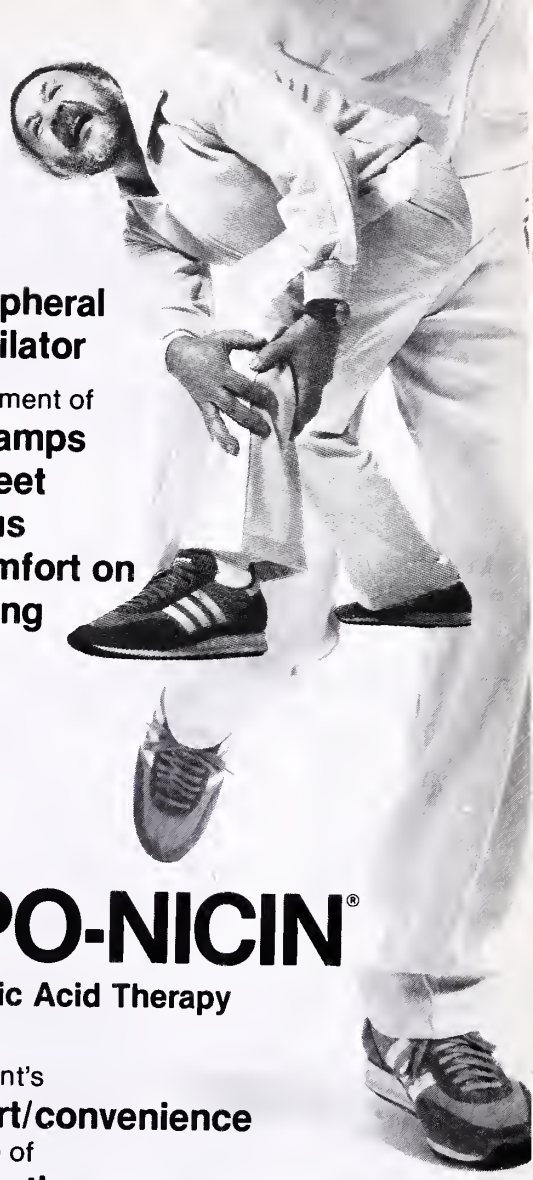
City & State _____

Send the bill for $15.00 (add 75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

OVER 100,000 PHYSICIANS READ POSTGRADUATE MEDICINE*

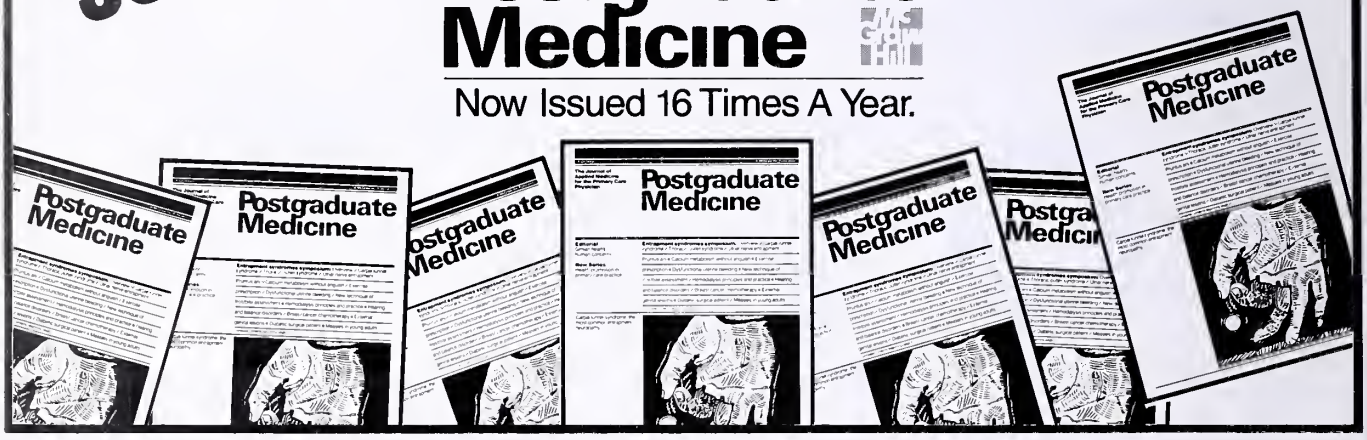
*January 1985 Media-Chek

MEDIA-CHEK

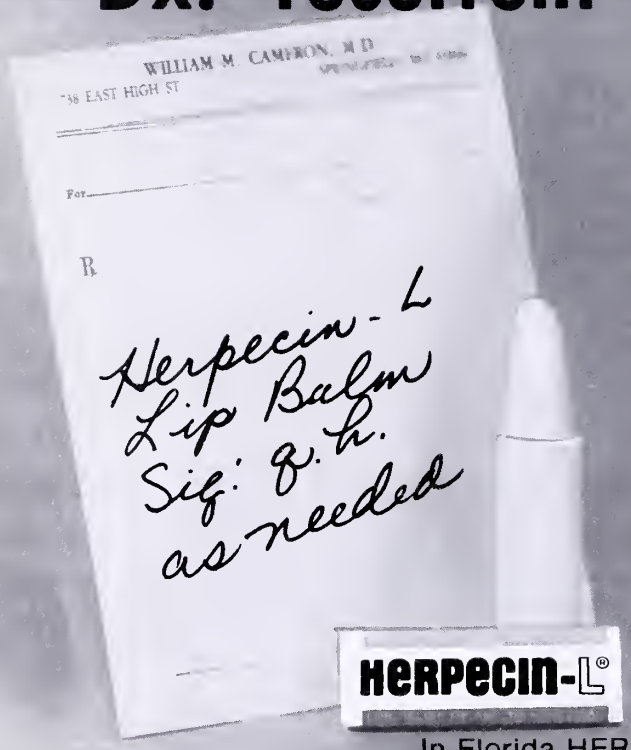
Join Them!

Postgraduate Medicine

Now Issued 16 Times A Year.



Dx: recurrent herpes labialis



"HERPECIN-L is my **treatment of choice** for perioral herpes." GP, NY

"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough.**" DDS, MN

"HERPECIN-L®. . . a **conservative approach** with **low risk/high benefits.**" MD, FL

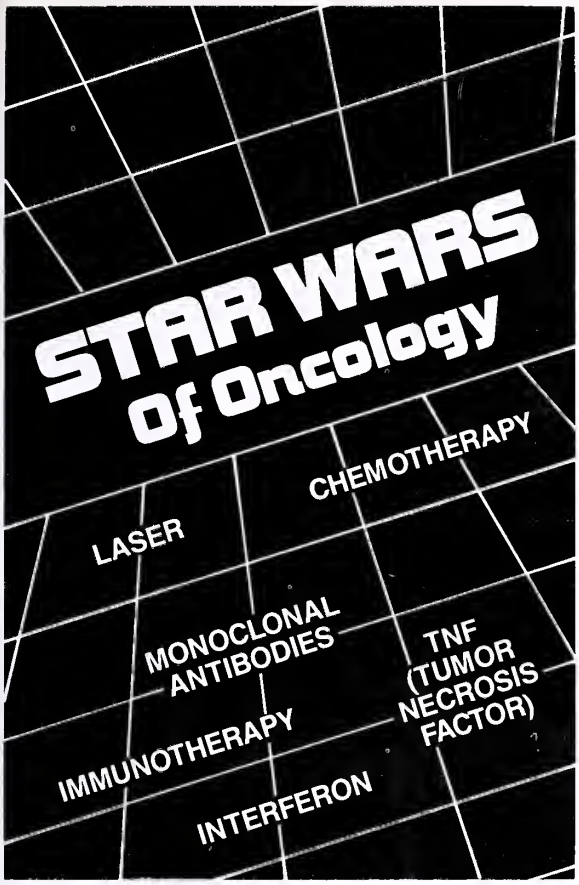
"Used at **prodromal symptoms** . . . blisters **never formed** . . . remarkable." DH, MA

"(In clinical trials) . . . **response** was **dramatic. HERPECIN-L** . . proven **far superior.**" DDS, PA

"All patients claimed **shorter duration** . . . at **prodromal symptoms** . . . HERPECIN-L **averted** the attacks." MD, AK

OTC. *See P.D.R.* for information. For samples to make your own clinical evaluation, write: CAMPBELL LABORATORIES, INC., P.O. BOX 812-MD, FDR STATION, NEW YORK, N.Y. 10150

In Florida HERPECIN-L is available at all *Gray, Revco, SupeRx Drug Stores* and other select pharmacies.



STAR WARS of Oncology

A one-day medical symposium presented by
South Highlands Hospital, Birmingham, Alabama

DATE: Friday, November 1, 1985
MEETING LOCATION: Birmingham Hilton
808 South 20th St.
Birmingham, Alabama

FEE: $65.00
Free for pre-registered residents
Free for medical students
CME Credit - 7 Hrs. Cat. I
FOR INFORMATION AND RESERVATIONS:
Call Mrs. Dena Metts, (205) 930-7703

Distinguished speakers to include, among others:
Richard M. Dwyer, M.D.—Laser Endoscopy Medical Group, Inc., Los Angeles, CA; Chief of Endoscopy, Harbor General Hospital, Terrance, CA; Clinical Assistant Professor of Medicine, U.C.L.A. Medical Center — "Management of carcinoma of the GI tract, including rectum and esophagus."
John S. Macdonald, M.D.—Professor of Medicine, Director, Division of Hematology/Oncology, University of Kentucky, Lexington — "Cancer chemotherapy: past successes and strategies for the future."
Thomas C. Merigan, M.D.—George E. and Lucy Becker Professor of Medicine and Head, Division of Infectious Diseases—Stanford University, Stanford, CA—"Immunotherapy of cancer in its broadest aspects. Interferon. Monoclonal antibodies."
Sydney E. Salmon, M.D.—Professor of Medicine and Director, Arizona Cancer Center, Tucson; Immediate Past President, American Society of Clinical Oncology—"A discussion of tumor necrosis factor. Biological response modifiers in cancer treatment."

FAMILY PHYSICIANS—GENERAL SURGEONS—INTERNISTS

Why, How and When?

flexible sigmoidoscopy

A 1½ day post graduate course and workshop

- *ACCREDITATION:* 10½ hrs. credit; Category 1, AMA, Prescribed credit A.A.F.P.
- *SPONSOR:* Medical Education Foundation of Miami
- *CO-SPONSORS:* South Miami Hospital, Florida Gastroenterologic Society
- *COURSE DIRECTOR:* John P. Christie, M.D.
- *REGISTRATION FEE:* $200.00 (Syllabus and luncheon included)

Sat./Sun., Nov. 2-3, 1985

The Key Biscayne Hotel and Villas, Key Biscayne, Fla.

For information, write to:
6614 Miami Lakes Drive East
Miami Lakes, Florida
(305) 687-1367

ADVERTISERS

Air Force
Recruitment 800

Army
Recruitment 772

Army Reserve
Recruitment 752

Ayerst Laboratories
Inderide LA 770a

BellSouth Mobility
Service 771

Brown Pharmaceutical
Android 740
Lipo-Nicin 807

Campbell Laboratories
Herpecin-L 808

Curtis 1000 Information Systems
Computers 780

Eli Lilly & Company
Keflex 784

E.R. Squib & Sons, Inc.
Corzide 743

Endocrine Society Postgraduate Assembly
Meeting 740

Florida Physicians' Insurance Reciprocal
Service 734

GTE Telenet
Service 792

International Conference Management Inc.
Meeting 796

Magnetic Resonance Imaging Center
Service 794

Marion Laboratories, Inc.
Cardizem 794a

Medical Education Foundation of Miami
Meeting 809

Parke-Davis
Norlestrin 753

Postgraduate Medicine
Publication 808

Roche Products, Inc.
Limbitrol 758
Dalmane 811

Shari Hospital Center
Recruitment 735

Southeastern Medical Data Systems
Service 797

South Highlands Hospital
Meeting 809

Sports Medicine Journal
Publication 806

University of Alabama
Service 736

The Upjohn Company
Motrin 734a

Willingway Hospital
Service 806

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Director and C.E.O.

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

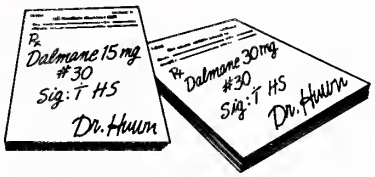
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓥ
sleep that satisfies

15-mg/30-mg capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. 3. Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. 4. Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. 8. Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
flurazepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

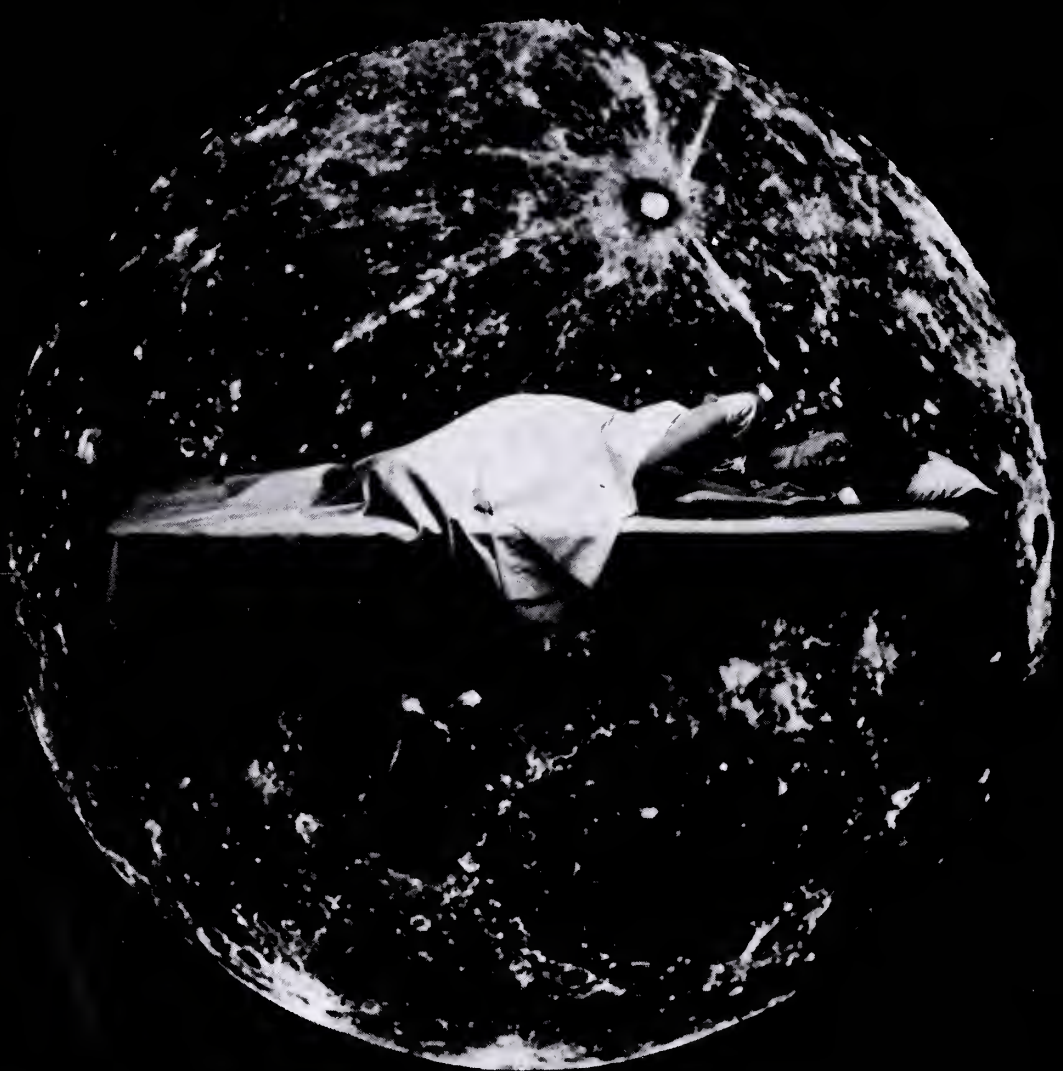
After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side

DALMANE®

flurazepam HCl/Roche ⓒⅣ

sleep that satisfies



ROCHE®

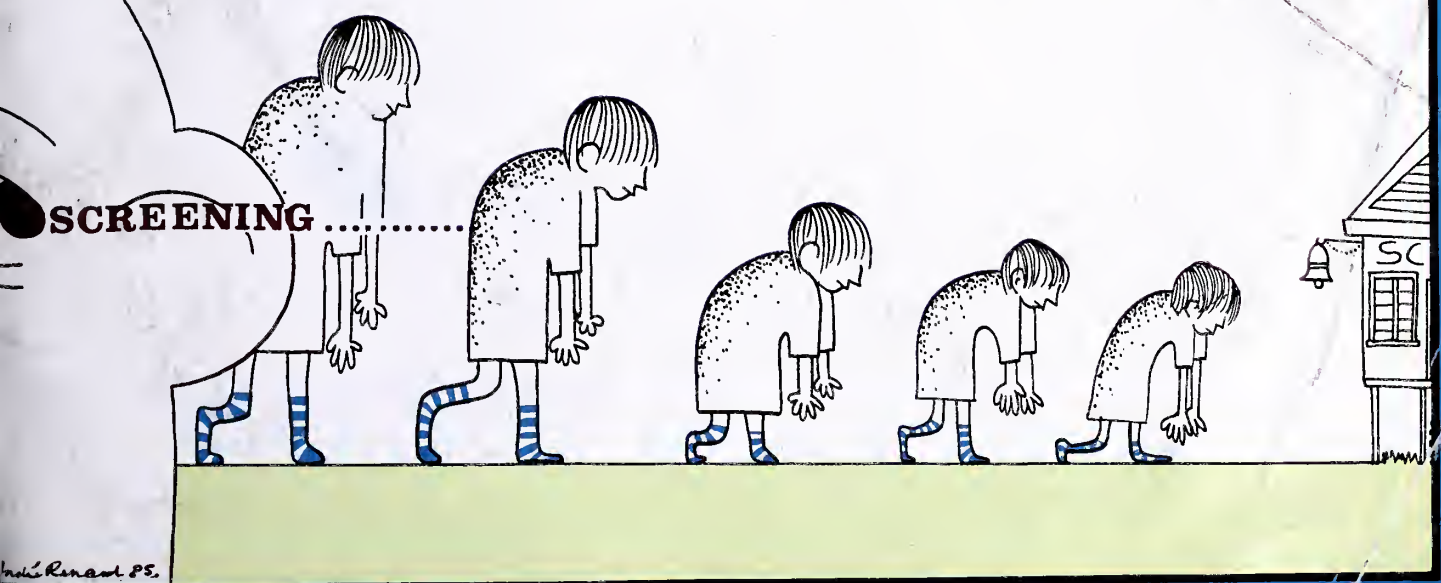
Copyright © 1985 by Roche Products Inc. All rights reserved

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. October 1985 Vol. 72, No. 10

NIH Claimed 2/11/86
B.O 7/2/87

back problems in children during school age.

CURRENT
COLUMBIA UNIVERSITY
OCT 30 1985
HEALTH SCIENCES
LIBRARY



BE ON THE BEST TEAM!



There is only one physician-owned, Florida Medical Association sponsored professional liability insurance company in Florida - - The Florida Physicians Insurance Reciprocal. The new Board of Directors has chosen the best management team possible to operate the Company and you need to be a member of the best team. This fine group of experienced insurance professionals is working hard to assure that the FPIR will be run as a conservative insurance business - - one that will be here for the tough games ahead.

Join the best team, now !

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

October 1985 "Doctors Helping Doctors" Vol. 2 — No. 4

AMA IP Conference In Chicago in April

The American Medical Association has announced that its Seventh National Conference on the Impaired Physician will be held in Chicago, April 10-13, 1986.

The Conference, conducted every other year, will have as its theme, "Reaching Out to Physicians . . .Their Families . . . and Allied Professions."

The 1986 conference will provide a forum for exchange of ideas and innovative approaches for those who work with impaired professionals, provide information to help implement and strengthen current programs, and stimulate the development of cooperative ventures among the professions.

Half-day sessions sponsored by national health organizations plus the AMA Auxiliary and the AMA Departments of Medical Student Services and Resident Physician Services will be featured. These will include presentations on impairment programs existing within these groups as well as examples of cooperative programs among various professions and organizations.

Additional information about the conference may be obtained by writing to: Ms. Janice J. Robertson, Department of Mental Health, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Rogers to Chair Section on Dependency

For the sixth consecutive year, the Committee on Impaired Physicians will sponsor a scientific Section on Chemical Dependency during the 1986 Annual Meeting of the Florida Medical Association.

The Annual Meeting will be at the Diplomat Hotel in Hollywood, September 17-21, but no specific date has been set for the chemical dependency program. Arvey I. Rogers, M.D., of Miami,

(Continued on Next Page)

Impaired Physicians Generate Costlier Malpractice Settlements

A preliminary study indicates there is a definite connection between physician impairment and medical malpractice, a New Jersey expert in chemical addiction told a Florida Medical Foundation-sponsored workshop last month.

David I. Canavan, M.D., Medical Director of the Medical Society of New Jersey's Impaired Physicians Program, said his survey was based on the cases of 61 impaired physicians in his program. While the number of malpractice cases generated by this group appeared to be smaller when compared with non-impaired physicians, the cost of settlement of each case was significantly higher, Dr. Canavan said.

"We are going to investigate this further," Dr. Canavan told participants in the Committee on Impaired Physicians' Sixth Workshop on Intervention with Impaired Physicians on September 28. "We hope to get a larger sample by cooperating with other states."

Dr. Canavan's program, now in its fourth year, has a current annual operating budget of $237,000, most of which is provided by two medical malpractice insurance companies in New Jersey. The state medical society and state veterinary and osteopathic organizations contribute the remainder. He quoted one malpractice insurance official that if the program spares his company one settlement a year the contribution is more than repaid.



Dr. Canavan

Dr. Canavan, who became the nation's first full time medical director of a state society-sponsored impairment program when he took the New Jersey post 3½ years ago, was the principal speaker at the workshop, which attracted about 50 physicians, nurses, veterinarians, podiatrists, pharmacists, attorneys and others. It was the first workshop program arranged by Roger A. Goetz, M.D., Medical Director of the Florida Impaired Physicians Program, since he came to Florida in February.

(Continued on Next Page)

Drinking Habits of Elderly Are Studied

The conventional image of people turning to alcohol when faced with traumatic events does not generally hold true for the elderly, research being conducted at the University of Florida indicates.

UF Sociologist Ronald Akers expected to find that the more shattering experiences an elderly person suffers, the more he or she would drink. "We found just the opposite effect," said Akers, who is surveying the drinking habits of 1,400 persons over the age of 60 under the sponsorship of the university's Center for Alcohol Research.

The elderly experience a high share of "significant life events" which include death of a loved one, being fired, retirement and divorce.

"If drinking is a response to these life events, you would expect to see an increased rate of drinking or problems associated with drinking developing late in life," Akers said. "But we found a negative correlation between life events and drinking. In other words, the elderly people reported they drank less than the elderly who had not been faced with the events.

"It could be that older people are better able to cope with stressful situations and are better able to plug into a supportive social network," he continued. "Perhaps the idea is that they have seen it all before and know 'This, too, shall pass.'"

Impaired Physicians (Con't)

Another speaker, John C. Eustace, M.D., Clinical Director of the Addiction Treatment Unit at Mt. Sinai Hospital, Miami Beach, told the audience that "most of the signs and symptoms of addiction are still behavioral."

Eight per cent of his patients have a second neuropsychiatric disease, and "we are going to see more of this because of all this use of drugs," he said.

He appealed to physicians planning to intervene with impaired colleagues to do their homework because the two principal causes of failure of intervention are inadequate preparation, including failure to get facts verified, and inappropriate timing.

"If we don't do something for ourselves and our colleagues, no one else is going to do it," he admonished.

Dr. Eustace's partner, Jules Trop, M.D., recalled that before Alcoholics Anonymous came on the scene a half century ago, alcoholics "went to jail, died or went crazy."

Now, with modern treatment methods, the recovery rate is high, he said.

He agreed with Dr. Eustace that a significant number of patients entering treatment exhibit one other primary disease and this means that "addictionology and psychiatry are going to have to work more closely together.

"This disease of addiction is chronic and it is incurable. We don't have pills, radiation and surgery. What is the percentage of recovery? You can do anything you want with statistics. But given proper tretment methods and a willingness to work at it, the potential for recovery is 100%, and there is no other incurable disease this can be said about."

Treatment, he said, must address all the physical, mental, psychological, familial and spiritual aspects of the disease, and "physical is the easy part."

The aim of treatment, he continued, is recovery and "total abstinance from all mood altering drugs." Many patients undergoing effective treatment "start to feel better than they ever felt before they got the disease."

Dr. Trop acknowledged there is sometimes recidivism among addicts, but "for some of us relapse is necessary for recovery."

"A good program has to use Alcoholics Anonymous or Narcotics Anonymous for a continuing support system," he said. "The disease doe not go away. The monkey on your back is not dead. He is sleeping."

Ronald J. Catanzaro, M.D., and his associates from the Palm Beach Institute in West Palm Beach, stressed the need to treat not just the addict but the family as well. PBI Program Director Jerry Singleton, M.A., said the symptoms of co-dependency include preoccupation with the disease of the alcoholic, a need to control and manage, emotional withdrawal and a sense of gloom and depression.

Lynn Hankes, M.D., Director of the Addiction Treatment Unit at South Miami Hospital, discussed the disease concept of chemical dependency.

"Somehow it's not a normal disease," Dr. Hankes told the audience. "It's the only disease that tells the patient he is not sick. But until the patient accepts the fact that he suffers from addictive disease, recovery is not possible."

Wilson Jerry Foster, J.D., a Tallahassee attorney who represents licensed health care professionals in disciplinary proceedings before their licensing boards, reviewed those provisions of the Medical Practice Act which relate to impairment. He also discussed the legal responsibilities of physicians to report impaired colleagues.

Dr. Canavan said he works with a three-tiered impaired physicians committee in New Jersey. The Executive Subcommittee, consisting of 13 members including students, residents and auxiliary members, works with the salaried staff in implementing policy and developing procedures and coordinates impaired physician activities in various regions of the State.

The next level is the Panel of Monitors and Intervenors which documents information, intervenes and participates in after-care monitoring. The third is the Human Resources panel consisting of physicians, spouses and others who can assist in various ways with the program and individual cases but who are not required to attend the committee meetings.

Dr. Canavan said he is not aware of any case in which an impaired physician sued a committee because of an intervention.

"Blowing the whistle on an impaired colleague is an act of love," he said. "We need to intervene early while there is something there to save."

He cautioned, however, that it is wiser to postpone an intervention until the essential facts on which the case is based are verified.

The intervention workshop was part of the Committee's continuing efforts to keep the medical profession in Florida up to date ondevelopments in all areas of addiction including intervention. The Committee has not determined when and where the next workshop will be presented.

Veterinary Executive Gets Committee Post

H. Larry Gore, D.V.M., of Orlando, Executive Vice President of the Florida Veterinary Medical Association, has been appointed an Advisory Member of FMF Committee on Impaired Physicians.



Dr. Gore

Dr. Gore and his organizations have been longtime ardent supporters of the Impaired Physicians Program. Several impaired veterinarians have been admitted to treatment through the IPP, and the FVMA earlier this summer contributed $6,000 to the program.

"I am honored and extremely appreciative that you and the Florida Medical Association Board of Governors have approved my appointment," Dr. Gore wrote to FMA President Luis M. Perez, M.D.

"Dr. Gore has been a true friend of the FMA and particularly our impaired professionals program," Chairman Guy T. Selander, M.D., of the Committee on Impaired Physicians, commented. "The program stands to benefit greatly through his official involvement."

Dr. Rogers (Con't)

has been designated program chairman, and the Florida Chapter of the American Medical Society on Alcoholism will be invited once again to co-sponsor the program.

The annual Section on Chemical Dependency is the focal point of the Committee's efforts to keep the medical profession in Florida up-to-date on scientific and other developments in the chemical addiction area.

ALZHEIMER'S DEMENTIA

Cure of the disease is still out of reach. In as devastating a condition as this, even the most modest relief of symptoms—or for that matter keeping them from getting worse or merely slowing their intensification—is a great contribution to patient and family.

HYDERGINE® LC (ergoloid mesylates) is indicated for patients over age sixty who manifest signs and symptoms of idiopathic mental decline. It appears that individuals who respond to HYDERGINE LC therapy are those who would be considered to suffer from some ill-defined process related to aging or to suffer from some underlying condition such as Alzheimer's dementia.

Before prescribing HYDERGINE therapy, the possibility that the patient's signs and symptoms arise from a potentially reversible and treatable condition should be excluded. In addition, because the presenting clinical picture may evolve to suggest an alternative treatment, the decision to use HYDERGINE therapy should be continually reviewed.

HYDERGINE® LC
(ergoloid mesylates)
liquid capsules, 1 mg

THE ONLY PRODUCT INDICATED FOR ALZHEIMER'S DEMENTIA.

© 1985 Sandoz, Inc.

HYD-1085-13

For Brief Summary, please see following page.

HYDERGINE® LC
(ergoloid mesylates) liquid capsules 1 mg



Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "Δ" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

HYDERGINE (ergoloid mesylates) tablets (for oral use); 1 mg, round, white, embossed "HYDERGINE 1" on one side, "Δ" other side. Packages of 100 and 500.

Each liquid capsule or tablet contains ergoloid mesylates USP as follows: dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "Δ" other side. Packages of 100 and 1000.

HYDERGINE liquid; 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg. [HYD—ZZ24—6-15-84]

Before prescribing, see package circular for full product information. HYD-1085-13

DORSEY PHARMACEUTICALS
Division of Sandoz, Inc. • East Hanover, NJ 07936

A SANDOZ COMPANY

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medieal Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of seientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for eaeh author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must aceompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be aecepted for publication, the agreement will be returned.



Put the world of medicine in your pocket every two weeks.

Right now, thousands of physicians like you are reading journals for in-depth information. But how can *anyone* keep up with the complex, rapidly changing world of medicine as a whole? By reading *Medical World News.*

For more than 115,000 busy physicians, *Medical World News* is the secret to staying in touch with the latest developments in therapy, research, practice, pharmacology, economics, legislative action, highlights of other periodicals and new medical trends.

We're doing it for them, and we can do it for you.

Every two weeks, we can bring you up-to-the-minute news from the nation's medical pressure points: Atlanta, Chicago, Dallas, Houston, Los Angeles, New York, San Francisco and Washington D.C. A network of contributing editors in major U.S., Canadian and European cities adds an international perspective to the mix. **Our policy of unbiased reporting gives you information you can trust.** And our easy-to-read style makes it enjoyable to stay informed.

medical world news The credible source.

©1985 HEI Publishing

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC

OCTOBER 1985, Vol. 72, No. 10

CONTENTS

SCIENTIFIC ARTICLES

Kresimir Banovac, M.D., Margita Zakarija, M.D., J. Maxwell McKenzie, M.D. — **835** Experience with routine thyroid function testing: abnormal results in "normal" populations

Eduardo Chapunoff, M.D., F.A.C.P, F.A.C.C., and Irwin B. Boruchow, M.D. — **840** Aberrant right subclavian artery as a cause of respiratory distress and dysphagia in an adult

Israel Alfonso, M.D. Richard G. Curless, M.D., Bernard H. Holzman, M.D., Arturo J. Aballi, M.D., Cosimo Ajmone-Marsan, M.D., Ivette Caram, M.D., Pedro F. Lopez, M.D. — **843** Computerized tomography and electroencephalography in childhood coma: which test should be performed first?

SPECIAL ARTICLES

Joseph C. Flynn, M.D., Max F. Reddick, M.D., Charles T. Price, M.D., Thelma L. Keller, P.T. — **847** Present status of scoliosis screening in Florida schools

Walter J. Morales, M.D., Ph.D., Betty J. Vaughn, M.D., N. Donald Diebel, M.D., Ph.D. — **852** The cost of no prenatal care

EDITORIALS

R. G. Lacsamana, M.D. — **825** New rules, new dilemmas

Edward Pedrero Jr., M.D., Ph.D. — **826** The only alternative

H. Frank Farmer, M.D., Ph.D. — **827** Battling the ghosts of yesteryears

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1985 by Florida Medical Association, Inc.

LETTERS & VIEWPOINTS

The Honorable Lawton Chiles **831** Dangers of designer drugs

COVER

This month's cover of *The Journal* is a drawing by Cover Editor Andre J. Renard, M.D., Jacksonville. The cover depicts the Special Article entitled "Present Status of Scoliosis Screening in Florida Schools."

DEPARTMENTS

Luis M. Perez, M.D. **821** President's Page
Indigent Care—a problem for all citizens

Jacques R. Caldwell, M.D. **857** Medical Economics
The pecuniary benefits of medical care

863 Notes and News

William B. Deal, M.D. **865** Dean's Message
Environmental adaptation

865 Encores!

872 Scam of the Month

875 Books Reviews

Mrs. Carol Van Eldik **879** FMA Auxiliary
Encouraging older adults to enjoy life

882 Meetings

886 Classified Advertising

894 Index to Advertisers

894 FMA Officers and Council Chairman

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
Frank H. Farmer Jr., M.D., Ph.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Philip Altus, M.D.
Fuad S. Ashkar, M.D.
Thomas D. Bartley, M.D.
Pierre J. Bouis Jr., M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Mrs. Dale R. Charneco
Charles Craig, M.D.
R. Jay Cummings Jr., M.D.
Raul V. deVelasco, M.D.
Pablo Enriquez, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
James T. Howell, M.D.
Harold L. Ishler Jr., M.D.
Nicholas H. Kalvin, M.D.
Karl J. Kramer, M.D.
Jeffrey Lang, M.D.
Michael S. Levine, M.D.
Richard F. Lockey, M.D.
Mr. Dale Matza
Philander D. Morgan, M.D.
George Morris, M.D.
Richard S. Panush, M.D.
R.A. Penalver, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
Arvey I. Rogers, M.D.
William J. Romanos, M.D.
Hubert L. Rosomoff, M.D.
Lees M. Schadel, M.D.
Frederick W. Schert, M.D.
Jack J. Schneider, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Roberto A. Sosa, M.D.
Michael E. Steier, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victoria, M.D.
George Watkins, M.D.
Charles D. Williams, M.D.
Frederic C. Wurtzel, M.D.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC. P.O. BOX 2411, JACKSONVILLE, FL 32203 TELEPHONE 904/356-1571

Indigent care—a problem for all citizens



In the sixties, when I started practicing medicine in Florida, it was taken for granted by all the physicians that a certain number of indigent patients were going to be seen every month in the office or accepted for admission to the hospital through the emergency room. It was considered part of the contribution to society by the physician and an integrant part of the profession.

Along came Medicare and Medicaid and the attitude of the physicians and the hospitals began to change. Everyone expected to be paid something by someone or by a third party, and the commercialization of medical care became intensified.

A few years later the liability crisis developed, compounding the problem. Certain groups of lawyers who found the "Horn of Plenty" in suing doctors and certain patients who in their greed look at this as a means of instant wealth have complicated this situation.

The fact remains that the medically indigent still exist; a significant percentage of the state's population can qualify as such. These people are very much in need of medical care. We have to devise a system which will provide medical care without compromising quality.

These patients, as a rule, present the most difficult problems, mainly because their lifestyle is so borderline from the standpoint of hygiene, self-care and nutrition. This easily complicates the cases and makes them more difficult to handle.

The problem is a problem of society. It has to be approached through public health and the citizens of the state. The concept of using a hospital tax to raise the necessary funds to care for the indigent is, in our view, a highly unfair solution. It is an added burden to patients treated in a hospital setting, while the rest of the population contributes nothing to the solution.

A more equitable arrangement would be an increase in the sales tax, where a moderate amount will go a long way, and all citizens will pay their fair share for the common good.

These tax dollars would have to be earmarked specifically for the purpose of financing the care of the medically indigent only. They should not be used to fund other types of welfare programs.

The Florida Medical Association is willing to pursue the study of all possible solutions. We are willing to meet with legislators and the Department of HRS representatives until a workable and realistic plan is developed to ameliorate the growing problem of the medically indigent.

Our efforts must be geared toward keeping our commitment to equal access to good quality care to all people regardless of economic means and status in society.

For a Nuclear Cardiology Consultation, Call a Specialist. MIST.



The University of Alabama Medical Center

The Division of Nuclear Medicine has a special nuclear cardiology program for performing a complete range of cardiac scintigraphy with comprehensive computer processing.

The Division performs all the traditional as well as the newest diagnostic techniques in the area of nuclear cardiology. Specialty services include:

- **Myocardial Perfusion Evaluation with Thallium 201, including stress studies (G.X.T.), drug studies and comprehensive quantitative studies to compare new patients to UAB nuclear cardiology data.**
- **Radionuclide Ventricular Function Testing including resting and exercise studies and evaluation of global and regional ejection fraction. These tests are particularly useful in coronary disease, valvular heart disease and primary myocardial disease.**

All studies are useful in cardiac rehabilitation programs.

The Division maintains the only tomography camera in the state, a Baird multi-crystal camera, and a fully-equipped nuclear cardiology stress laboratory.

The Division is one of 60 departments, divisions and centers of the University of Alabama Medical Center accessible to you through the Medical Information Service via Telephone (MIST).

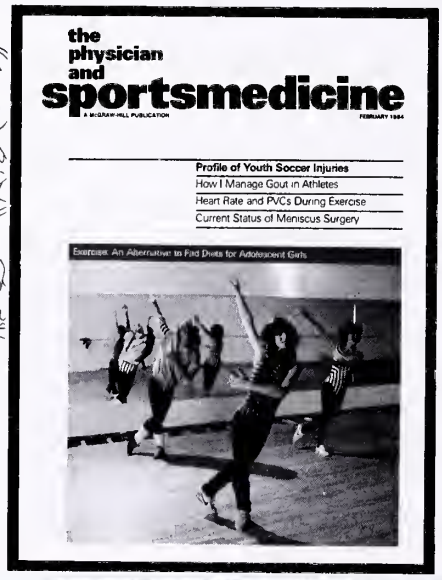
The Division of Nuclear Medicine welcomes physician inquiries. Telephone MIST to speak with a physician, to consult about a patient, to refer a patient, or to request a patient transfer via the Critical Care Transport Service.

MIST
Medical Information Service via Telephone

UAB University of Alabama Hospitals
University of Alabama at Birmingham

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.



BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg





New rules, new dilemmas

Editor's Note: This editorial appeared originally, under a different title, in *The Stethoscope* of Volusia County Medical Society, Winter issue, 1984. It was expanded and modified by the author for *The Journal.*

The practice of medicine used to be a simple transaction: the physician examined the patient, rendered a service, and got paid for it. The patient usually did not question the physician on what he did; neither did anybody else. But as medical practice has become more complex and expensive, usually involving the employment of an array of diagnostic and therapeutic services and procedures, and as increasing competition in medicine is compelling a number of physicians to devise certain economic strategies, new concerns and new questions have popped up. One major focus by patients and recently by the government, insurance companies, and the medical profession is on the physician: what he does, how much he does, and whether what he does is appropriate or not. The reason for this changing and often skeptical attitude is the fact that the modern physician has the potential to expand his practice and offer a variety of services in which he may have a vested interest. More services means more money, and therein lies the crux of a thorny dilemma: the conflicts of interests that are rampant in today's medical setting.

In times past, physicians did not have to confront such conflicts of interests. Ethical restraints and government regulations made it impossible for physicians to make profits except for fees generated from direct services to patients. A classic and oftenquoted example of the old rules was the prohibition on owning drug stores by physicians. This made a lot of sense. Physicians, in writing prescriptions, did not get sidetracked by the possibility of extra profits while seeing their patients. This aura of incorruptibility conferred by such rules kept the public image of physicians clean and unsullied. The public, after all, does not expect physicians to be businessmen at the same time.

But we are in a new age of medicine and the rules of the game are changing fast. With new government regulations that are altering the patterns of medical practice and promoting more free enterprise in the medical marketplace, an increasing number of physicians are scrambling to partake of opportunities not previously available. Despite the traditional ethical restraints, more physicians are now practicing like businessmen. It is not without reason that "entrepreneurship" has become a favorite buzz-word in many medical circles today. The more procedures and services he employs in his office, and the more financial interests he has in all sorts of ventures — whether these be with hospitals, corporations, insurance companies, or other physicians — the more the physician stands to gain from his practice. This practice is abetted by the fact that Medicare and medical insurance companies dole out hefty reimbursements for almost everything. Under this new and unfettered climate, it is not unusual for many physicians to see their incomes doubling or even tripling without working additional hours.

It is only fair to state that the majority of physicians who have equipped their practices with additional services and paraphernalia did so for the convenience of their patients. A case in point is the setting up of small laboratories by primary care practitioners in their offices. Drawing blood samples, doing simple tests, and sending specimens to commercial laboratories for more complex tests is not only more convenient for patients; it is also much less expensive than sending patients to hospital

laboratories, for example. New and more stringent Medicare reimbursement policies for outpatient laboratory work also obviate the possibility of abuses. Nevertheless, despite the honesty of most physicians, their increasing involvement in profit-making medical ventures disturbs the equanimity of those who feel that the situation deserves further scrutiny.

There is nothing inherently wrong in making a profit out of one's honest work; but at the same time, it can also impel certain unscrupulous physicians to do things in blatant disregard of patient's interests. The allegations, for example, that some physicians have been consorting with certain manufacturers of pacemakers and intraocular lenses for financial favors, if true, can only fuel suspicion that physicians cannot be trusted. What they do may be legal and medically justifiable on the surface, but is it right and ethical? Part of the problem is the fact that medical practice is getting grossly commercialized, with the rules of the marketplace having replaced largely the older ethical codes. Another problem is the lack of effective mechanisms within the medical profession to monitor physicians' activities. Most physicians who abuse the system get caught usually by accident by other physicians or by a few vigilant patients who know when some hanky-panky is going on.

It may be argued that most current arrangements which allow physicians to participate in economic ventures are above-board and perfectly legal when tested against the profession's most stringent standards. For example, physicians banding together to open a diagnostic laboratory or an imaging center are at most just displacing other third parties like pathologists, radiologists, or a big corporation from reaping the usual profits, or perhaps sharing the profits with them. A group of surgeons opening an ambulatory surgical clinic may in fact be saving their patients a lot of money, even if this means greater economic returns for the surgeons in the long run. For those who feel that there are still conflicts of interests in such situations, public disclosures by physicians of their interests in these enterprises, as is now required by some states, may quell the anxieties of skeptical physicians and the public. Patients at least will know from the outset that something is not being withheld from them. Whether such public disclosures will curb potential abuses of the system can be answered only with time.

Amidst all the developments swirling about them, physicians, like Caesar's wife, must be above suspicion and ultimately must abide by ethical codes of conduct rooted deeply in the medical profession. The changing mores in medical practice must not distort our perspective that, as physicians, we are the trusted guardians of our patients' interests. If we do not wish to live by the old-fashioned values which have distinguished our profession in the past, the government and other outside forces surely will step in and start dictating to us, as they have already done. It is a simple choice of eschewing our principles or adhering to the creed of doing what is right.

R. G. Lacsamana, M.D.
Editor

The only alternative

"Working men of all countries, unite!" For more than a century this final sentence of *The Communist Manifesto* co-authored by Karl Marx and Friedrich Engels has echoed throughout the world. It is most appropriate now for a similar phrase — Physicians of all counties, unite!

The American physicians are on a watershed between a dying medical system based on individualism and a collective medical system being formed in which the supposed free development of each will be the condition for the free development of all.

It is fashionable for many physicians to talk, almost complacently, of the rendezvous with doom in socialized medicine. Some physicians feel that they have already been robbed of their will power and individualities and are flies in the web of an irascible spider called bureaucracy. Physicians must feel like little atoms trying to maintain their own sanities and equilibriums in the midst of all increasing molecular upheaval.

The medical bureaucrats are pregnant with possibilities that the prophecies of the doom of organized medicine in America will soon be realized. The prophecies of doom are heard today with increasing frequency; some of our national leaders claim that the physician's personal and social future is guaranteed by our material effectiveness. These realists are ignorant of the hard facts. They do not see the emptiness and planlessness of the average physician's life. They do not believe that the average medical doctor lacks faith in the national medical associations. They do not see that if this lack of faith continues, it will incapacitate organized medicine.

Some physicians question the value of the methods of associations into which the strands of organized medicine are woven. Some wish to strengthen and extend the ties while others wish to reexamine, reduce and even eliminate the enmeshment of medical associations and specialist societies. Nonparticipation by physicians weakens the web of interdependence.

Physicians must abandon the quietistic attitudes towards nationalized/socialized health care. The present state of affairs can never be remedied by

editorials alone or bogus gestures of resistance. Physicians must not remain insulated from reality — the often cursed AMA with its official answers and actions cannot solve all the problems. The silent majority can no longer justify their inactivity.

Isn't this the time for the silent and inactive physicians to strip off exterior trappings and to realize their own central ego-consciousness and spiritual nature more perfectly?

Physicians cannot be isolationists from the organizations that represent them. We practice in a complex professional, economic and social framework that responds to a variety of pressures. Alone we are unable to exert much influence on that framework. Collective strength depends on the individual physician/county/state/national organization symbiosis.

There is a tendency for most physicians to believe somebody else will solve the problems. Somebody else will mend the leaks of the liability insurance dikes. Somebody else will remove the inequalities in fee schedules, beautify the dehumanized medical landscape, vindicate the innocent and punish the wrongdoers. Most physicians will not overcome the habit of "letting George do it."

These are not the times for a medical discipline of silence, simplicity, contemplation and self-effacement. This is not the time for a medical mysticism of introversion and withdrawal. The silent medical majority can no longer justify their inactivity.

An active medical majority can regain the power and dignity of the profession and can vehemently thrust forward as an entity charged with energy and structural in specific ways that will have no expressions of weakness and self-negation.

Inactive physicians can and must overcome the inertia of channeled routine. Physicians affiliated for action and possessing some measure of resiliency, drive and endurance can stimulate the powers that be to make changes.

With conciliation, adaptation and dialogue, the active medical minority can attain unity and solidarity with the silent inactive medical majority. Together, the medical profession could be an inexhaustible source of creative dynamism.

How much longer will physicians be indifferent and helpless to the bombardment of their battered egos with books, speeches and articles dramatizing their superfluities?

How far will the diversifying factors of the medical bureaucracies' pendulum go before the silent majority and the active minority of medicine unite?

All physicians should remember the words of William Jennings Bryan, "The humblest citizen of all the land when clad in the armour of a righteous cause is stronger than all the hosts of error."

Physicians of all counties, unite! This is the only alternative. United, we can see medical bureaucratic caprice curtailed!

Edward Pedrero Jr., M.D., Ph.D.
Contributing Editor
Tampa

Battling the ghosts of yesteryears

Practicing medicine today is not an easy task. In fact, it is downright frustrating as we must not only keep abreast with new medical technology, but must also face decreased public confidence and occasional animosity from a large segment of the patient population. In thinking about how we as physicians happened to end up in this undesirable position, it has become clear to me that, while we must accept our share of the blame for this turn of events, it is also apparent that there are other factors involved, most of which we did not manufacture or cause to occur. Ironically, we are, to some degree, a victim of ghosts past and at the same time answerable to the new technological society in which we presently live. By this, I mean that we may not be able to shed our comparison with the image of the "old-time doctor" and its implied attributes of goodness, noble purpose, and a caring person. This is in contrast to the modern caricature of doctors with our implied image being one of uncaring and money-grabbing individuals, unavailable to patients, and a danger to the public at times. At the same time, modern day physicians are held accountable to standards which approach almost perfection. We are expected to practice and be familiar with all the latest technology. If we falter in our knowledge or application of this technology, the patients may extract their pound of flesh in the form of a multimillion-dollar malpractice suit.

As I pondered these thoughts over and realized how we came to this end, I have come to several conclusions. The first is that being compared with the image of the old time doctor, which by its mere mention conjures up almost a priestly vision, we will never measure up. The simple fact is that no profession can stand up to this ghost of the past. The public has an image of what the doctor of yesteryear was: he was loving, caring, unselfish, unmindful of his own welfare, unconcerned about money, and all knowing. This is the scale by which we are measured by a large share of the public. Not only is it a comparison that is critical of present day doctors; it is also erroneous. Alas, not only are we compared to an

idealistic example, but one which probably never existed and was in fact disliked and distrusted by a large portion of the public of his time. Physicians from 1900 to 1950, which is usually the period in which the "good doctors" lived, as perceived by the public today, were not as many have painted them to be. Medicine was not hailed as a great healing art in that period of time. This was a result of several things. Scientific medical education had just been implemented in the years after the Flexner Report of 1910 and many graduates of inferior medical schools or apprentice programs were still practicing in great numbers. Medical quackery with worthless medicines and gadgetry abounded in the 1920's and 30's. Medical specialization boards did not really get off the ground until the 1920's, with the result being that much specialized surgery was being done with terrible results. The government had only recently passed any laws designed to protect the health of Americans. The public knew this and tended to shy away from doctors if at all possible. If major surgery or illness was involved, those who could afford it went to the few prestigious medical centers of America. Those who could not had to endure the ministries of the local profession, but most feared and loathed it.

It was almost impossible to separate quackery from accepted medical doctrine, which may have done more harm than the quackery. How then did the present-day perception of the "old-time doc" emerge? The old-time doctor is what they would like to have. However, when they had it, they really wanted something else. They wanted a doctor to cure them. They wanted the Mayo Clinics, the John Hopkins Hospitals and all the other wonderful innovations which the emerging age of technology promised them. No, the adoration and nostalgia was not for the medical care. It was because physicians are remembered and revered not as physicians, but as members of a priestly class. Since the healing aspect of medicine was very limited, the role of physicians became one of comforters of the sick and friends of the bereaved. I suspect that the number of physicians who were actually this caring were no more on the average than can be found in our present day physician population. However, no matter how small the percentage of physicians of yesteryear, who fit this mold, the present day perception has assigned it a composite picture and we are consigned to being compared to a ghost.

Ironically, the very thing which the public wanted prior to World War II — medical care based on scientific principles — has now come about, yet the very advance of technology has led to more troubles. This scientific revolution has led to new means of treatment with antibiotics, organ transplants, etc. We as physicians have immersed ourselves with years of residency and specialty training, but the price of medical care, as you would expect, has gone up. We find ourselves in the position of delivering more modern technological care than our forefathers and doing it at the request of the public. Yet, the more medical care we deliver, the more we are compared unfavorably with our medical ancestors. It is a paradoxical situation.

This is not to justify unfeeling physicians nor to say that compassion and technological competency are mutually exclusive. Indeed, I feel, as most doctors do, that we as physicians have to be more caring, more compassionate and more responsive to the needs of the public. Somewhere along the line after World War II, these qualities were subjugated as we delved more into the miracles of modern medicine. We are now at the point where we are able to give the best medical care in the world, but apparently are less liked than our medical ancestors who gave very little medical care. The physicians of the past probably were more caring and spent more time with their patients than we today do. That is partly because they had little else to offer. At the same time, I recognize that there is some validity, indeed much validity, in the complaints against the physician today in which we are painted as less than caring individuals. Again I feel that technology and caring can be mutual and complementary attributes of current medical practice. But in being compared with the ghosts of the past, we will never "pass muster".

What we need to do is to strive to incorporate in our new technological approach those aspects of yesterday's medicine which we all recognize as good and desirable traits.

H. Frank Farmer, M.D., Ph.D.
Historical Editor
New Smyrna Beach

Physicians' Confidential Assistance

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians



The appearance of these tablets is a registered trademark of Wyeth Laboratories.

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (lorazepam) **for Anxiety**

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101



© 1985 Ayerst Laboratories

Once-daily INDERIDE® LA

The world's leading beta blocker and diuretic—for once-daily convenience without compromise

When selecting other once-daily agents, physicians may have to compromise either their choice of beta blocker or diuretic. With INDERIDE® LA, physicians have the agents most widely prescribed worldwide—INDERAL® and hydrochlorothiazide—with the convenience of once-daily dosage.

24-hour blood pressure control with the broad benefits of INDERAL (propranolol HCl)

The controlled-release delivery system of INDERIDE LA provides 24-hour beta blockade and the broad cardiovascular benefits of INDERAL with a single daily dose. Compliance is enhanced because once-daily administration fits easily into patients' daily routines.

Plus standard-release hydrochlorothiazide, the thiazide of choice for comfortable morning diuresis

Hydrochlorothiazide is the world's most widely prescribed antihypertensive diuretic. When taken in the morning, INDERIDE LA provides comfortable morning diuresis. Each dosage strength of INDERIDE LA contains:

—one of the three most widely prescribed dosage strengths of INDERAL® LA—80 mg, 120 mg, or 160 mg and

—an established, effective daily dose of standard-release hydrochlorothiazide—50 mg

New once-daily

INDERIDE® LA

Convenience without compromise

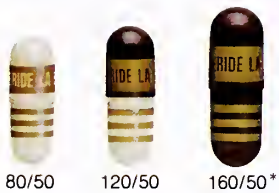


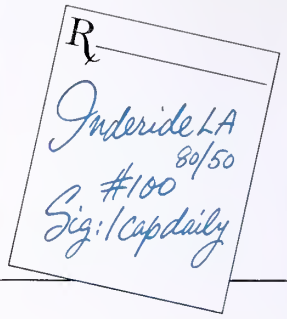
80/50 120/50 160/50*

*The appearance of INDERIDE® LA Capsules is a registered trademark of Ayerst Laboratories.

Please see following page for brief summary of prescribing information

Once-daily
INDERIDE® LA
Convenience without compromise
One capsule—Once daily





*The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERIDE® LA Brand of **PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)**

No. 455—Each INDERIDE® LA 80/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 80 mg
Hydrochlorothiazide 50 mg

No. 457—Each INDERIDE® LA 120/50 Capsule contains:
Propranolol hydrochloride (INDERAL® LA) 120 mg
Hydrochlorothiazide 50 mg

No. 459—Each INDERIDE® LA 160/50 Capsule contains:
Propranolol hydrochloride (INDERAL® LA) 160 mg
Hydrochlorothiazide 50 mg

INDERIDE LA is indicated in the management of hypertension.

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia; congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

Central Nervous System. Dizziness, vertigo; paresthesias; headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

Ayerst® AYERST LABORATORIES
New York, NY 10017

Dangers of designer drugs

Designer drugs are looming as a new and potentially overwhelming threat in our efforts against drug abuse. Because of the nature of this problem and the impact it has on doctors, treatment center specialists, coroners and others in the medical field, I want to take this opportunity to bring it to the attention of *The Journal of the Florida Medical Association, Inc.*



Sen. Lawton Chiles

Designer drugs are chemical analogs of substances scheduled under the Controlled Substances Act (CSA). The term "designer drug" was coined by Dr. Gary Henderson of the University of California at Davis, who first became aware of the scope of this frightening new trend in drug abuse. Several years ago he found that clandestine chemists working in underground labs were producing a variety of these drugs and altering their chemical effects to suit the euphoric tastes and abusive desires of customers. Because the drugs vary slightly from the chemical formulas covered by the CSA, the chemist or user who is found to possess them cannot be prosecuted.

Designer drugs are extremely dangerous from a health standpoint. The drugs are thousands of times more potent than the illegal narcotics presently flooding this country. Over one hundred deaths have been attributed to designer drug use so far. Furthermore, these drugs have been linked to long term neurodegenerative diseases in some users. The human and medical economic costs of designer drugs are potentially devastating.

The designer drug phenomenon poses specific difficulties for those in the medical profession. Because the drugs are made in unregulated labs, each batch is likely to contain contaminants. One such case is being studied by Dr. J. William Langston, chairman of the neurology department of Santa Clara Valley Medical Center.

Dr. Langston has identified over 400 young people who took a designer variation of Demerol. Some of these users have symptoms identical to those exhibited by victims of Parkinson's disease. In synthesizing an analog of meperidine, 1-methyl-4-phenyl-4-proprionoxy-piperidine (MPPP), often 1-methyl-4-phenyl-1,2,5,6-tetrahydropyridine (MPTP) is made due to poor lab conditions. MPTP kills exactly the same brain cells which die when one has Parkinson's disease. Though some of these patients have responded to treatment using L-dopa, which is used to treat Parkinson's patients, this relief is only temporary.

Moreover, while most of the victims of MPTP contaminated drugs are currently asymptomatic, there are scientific reasons to fear that all of them may be at higher risk of developing a Parkinson's like condition in the future. In fact, a senior investigator at the National Institute of Health has referred to them as "walking time bombs." The cost of treatment and possible institutionalization of these people will be great. The terrible human cost of these young lives destroyed by designer drugs will be even greater.

Further, some designer drugs have been found to be as many as 7,000 times more powerful than morphine. Often the minute amounts that can be fatal are too small to be found in tests by medical examiners. Dr. Ronald K. Wright, Chief Medical Examiner of Broward Medical Examiners Office, wrote

to me that designer drugs "are a nightmare for those of us charged with determining the causes of death of people who die suddenly and unexpectedly. The minute amounts capable of producing death are very hard to find. Thus, we suspect more deaths are occurring than are being reported." A statewide meeting of medical examiners in Florida in October will focus on designer drugs as medical examiners and law enforcement officials try to get ahead of the curve, try to stop the phenomenon of designer drugs before it gets to the disaster stage.

We need only remember the devastating effects of LSD in the 60's and PCP in the 70's to realize that the designer drug problem must be addressed now. I have been working during this Congress to focus national attention on the problem and to find solutions.

In March, I introduced legislation which required the National Drug Enforcement Policy Board to review the problem and make recommendations to Congress for necessary legislation. A short while later, I secured from Attorney General Meese a commitment to move expeditiously on the problem.

Then in July I held hearings in Washington which brought together Dr. Henderson, Dr. Langston, law enforcement officers from California and Florida and others involved in the designer drug phenomenon.

I am pleased to announce that as a result of these efforts, legislation which addresses the designer drug problem has been introduced in this Congress. In the Senate, S. 1437 would impose penalties of 15 years imprisonment and a $250,000 fine to anyone convicted of manufacturing, distributing, or possessing with intent to distribute, any designer drug.

This is just the beginning of working toward a solution. I feel it is essential that medical professionals, law enforcement agencies, representatives from the pharmaceutical field, educators, and government officials work together in addressing this problem. Organizations like the Florida Pharmacy Association have worked to educate independent pharmacists about designer drugs and to make them aware of steps each can take to prevent being an innocent accomplice to a designer chemist's work. I encourage other groups to take similar action and would be pleased to provide assistance in such efforts.

The Honorable Lawton Chiles
United States Senate
Washington, D.C.

Getting ahead in medicine is an uphill climb.



Unless you have a BellSouth Mobility car phone.

Turn drive time into prep time. This year, our car phones are going to be one of the most popular ways for doctors to control high blood pressure—their own.

Because BellSouth Mobility cellular car phones allow doctors to stay in constant touch. To plan ahead. And to have the frustration of the pay-phone routine painlessly removed by allowing you to give your service an immediate buzz when you get beeped on the road.

Advanced service network. Ours is the most advanced phone system on wheels. It's just as easy to use as your office phone. And it's the only one with a state-of-the-art service network behind it. Making sure that your car phone—and your patience—are state-of-the-art. Now, and down the road.

Call BellSouth Mobility toll-free at 1-800-351-3355. And from there, it's all downhill.

BellSouth Mobility

All you need to know about mobile communications.℠

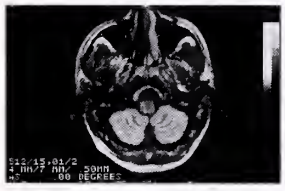
©1985 BellSouth Mobility Inc

Our new Magnetic Resonance Imaging Center will help you care for her, as no one else can.





MRI utilizes a combination of magnetic and radio frequency fields rather than X-rays.



MRI enables you to see past bone for better clarity of image.

Magnetic resonance imaging is one of the most advanced, most accurate diagnostic tools.

It's also one of the safest. It doesn't use X-rays, so there's no concern about radiation side effects. No contrast media is needed, so there's no discomfort and little chance of allergic reaction.

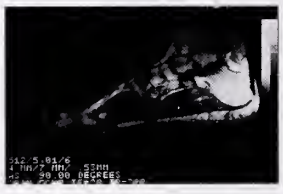
But there's one thing the MRI Center can offer that few others can. The staff of Miami Children's Hospital. People trained and experienced in the special care and consideration you want for your young patients.

Find out more about our MRI Center. Call us today to arrange for a guided tour or a free brochure at (305) 662-1564. Or use the coupon below.

M·R·I
DIAGNOSTIC CENTER
miami children's hospital



MRI allows you to identify diseases that were previously recognizable only during a surgical procedure.



Multiple images of the human body are available from sagittal, coronal, and axial perspectives.

I'd like to know more about the Magnetic Resonance Imaging Center at Miami Children's Hospital.

☐ Please call me to arrange a tour.
☐ Please send me a free brochure.

Name

Title

Address

Area Code/Telephone

Best Day/Time to Call

Complete and mail to Miami Children's Hospital, 6125 Southwest 31st Street, Miami, FL 33155. Or call (305) 662-1564.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
OCTOBER 1985, Vol. 72, No. 10

Experience with routine thyroid function testing: abnormal results in "normal" populations

Kresimir Banovac, M.D., Margita Zakarija, M.D., and J. Maxwell McKenzie, M.D.

ABSTRACT: Thyroid function tests and prevalence of thyroid antibodies were studied in 586 blood donors and in a group of 135 normal pregnant women. Abnormal tests were found in approximately 8% of blood donors and 3.7% of pregnant women. Positive titers of antibodies to microsomal antigen occurred in 10% of blood donors and 9% of pregnant women. FT_4 and FT_3 concentrations in male subjects were significantly higher than in female ($p < 0.001$). Serum TBG concentration in women was 29.8 ± 5.8 mg/L which is significantly higher than 25.8 ± 5.1 mg/L in men ($p < 0.001$). These data suggest that a significant number of blood donors have abnormalities of thyroid function tests and/or significant titers of thyroid antibodies, which may indicate need for more detailed thyroid function screening for determination of normal ranges for thyroid function tests.

The Authors
KRESIMIR BANOVAC, M.D.
MARGITA ZAKARIJA, M.D.
J. MAXWELL McKENZIE, M.D.
Dr. Banovac is Assistant Professor, Dr. Zakarija is Professor and Dr. McKenzie is Professor of the Division of Endocrinology, Department of Medicine, University of Miami School of Medicine, Miami.

This study was undertaken to determine the normal values of thyroid function tests for a routine thyroid laboratory using available commercial kits. We used bloods obtained from a group of clinic blood donors and from normal pregnant women attending a prenatal clinic.

Materials • Five hundred eighty-six blood donors, 250 men and 336 women, consented to participate and 135 normal pregnant women also donated blood. The donors denied having acute or chronic illnesses but no detailed clinical evaluations were carried out. The pregnant women were considered by their obstetricians to be free of intercurrent medical disorders. The average age of the total group was 34 years for men (range 20-60) and 33 years for women (range 19-61).

Methods • Serum was separated from clotted blood and stored at −20 C until used for the following assays: total and free thyroxine (TT_4 and FT_4), total and free triiodothyronine (TT_3 and FT_3), reverse triiodothyronine (rT_3), T_3 uptake test (T_3U), thyrotropin (TSH), thyroxine binding globulin (TBG), thyroglobulin antibody and antibody to the thyroid microsomal antigen. T_3U was used in conjunction with the serum T_4 determination to derive the Free Thyroxine Index (FTI).

The following commercial RIA kits were used in the study: T_4, T_3, TSH and T_3U from Becton-Dickinson, Immunodiagnostics, ARIA II System, Salt Lake City, Utah; thyroid microsomal antibody and thyroglobulin antibody test, Ames Division, Miles Labs., Elkhart, Ind. Serum FT_4 concentration was determined by use of a labeled T_4 analogue (Magic — single step FT_4 RIA — Corning), serum

Table 1A. — Values of Thyroid Function Tests in Blood Donors.

Subjects	Age	T_4 ug/dl	T_3 ng/dl	rT_3 ng/dl	T_3U %	FTI
Male	33.7 ± 9.8*	7.1 ± 1.1	149 ± 24	22.2 ± 5.7	30.6 ± 2.9	7.2 ± 1.1
Range	20 - 60	4.8 - 10.9	83 - 222	14.6 - 35.1	24.1 - 38.2	4.9 - 11
n	250	246	263	25	246	247
Females	33.1 ± 10.8	7.6 ± 1.3**	137 ± 24**	20.7 ± 4.8	28.9 ± 2.8**	7.3 ± 1.1
Range	20 - 61	4.6 - 10.6	88 - 208	12.3 - 37.7	23.0 - 36.6	4.2 - 10.1
n	336	296	297	82	296	296
Total	33.4 ± 9.9	7.4 ± 1.2	143 ± 2.4	21.2 ± 5	29.7 ± 2.9	7.2 ± 1.1
Range	20 - 61	4.6 - 10.9	83 - 222	12.3 - 37.7	23 - 38.2	4.2 - 11
n	586	542	560	106	542	543

*mean ± SD
**$p \ll 0.001$ vs males

FT_3 concentration by Amerlex Free T_3 kit (Amersham) using a ^{125}I-labeled deritive of T_3. Serum TBG and reverse T_3 concentrations were measured by radioimmunoassay, Serono Diagnostics, Inc., Braintree, Mass.

For all procedures we followed the manufacturers' recommendations precisely and used the standards provided. All sera were analyzed in duplicate. Control sera with low T_4, T_3, and normal TSH concentrations and elevated T_3U value were from Becton Dickinson Immunodiagnostics. A pool of sera obtained from normal pregnant women was used as a standard with an elevated T_4 and T_3, and low T_3U value. The data were transferred to punch cards that were then processed using the HESM31 528 Univac 1100 program. Evaluation of statistical significance of differences was by "t" testing with a 95% limit of significance. The intraassay coefficient of variation (CV) for the control serum (80 assays) was 0.85% for T_4, 3.2% for T_3, and 1.6% for TSH. The interassay CV was calculated for standards with decreased and elevated T_4 and T_3 concentration, normal and elevated TSH concentration and low and high T_3 uptake values; for low and high T_4 this was respectively 4.4% and 3.8%, for T_3 10.3% and 7%, and for T_3U 3.1% and 3.5%. The interassay CV for sera with high and normal TSH concentrations was 15.7% and 15.4% respectively. The quality control studies for the thyroid function tests were part of the Proficiency Testing Program of the Center for Disease Control, Department of Health and Human Services, Atlanta Ga., and the Interlaboratory Comparison Program, College of American Pathologists, Skokie, Ill.

Results • Table 1A lists the values of thyroid function tests in blood donors; normal values may thus be defined as shown in Table 1B. The mean serum T_4 concentration was higher in women than in men ($p \ll 0.0001$), while the mean T_3 concentration and T_3U were higher in male than in female donors ($p \ll 0.001$). There was no statistical difference in FTI values between these two groups.

For pregnant women, Table 2 summarizes typical results, i.e., elevated total T_4 and T_3 and TBG in addition to a decrease of T_3U. In this group a maximal individual value of serum T_4 concentration was 16.7 ug/dl, for T_3 254 ng/dl and for TBG 69.9 mg/l. However, the range of FTI was similar to that found in normal nonpregnant subjects.

Serum FT_4 and FT_3 concentrations were significantly higher in normal male blood donors than in females ($p \ll 0.001$); serum TBG was lower in males than in females ($p \ll 0.001$) (Table 3).

Table 4 shows the values of serum TSH concentrations in blood donors. TSH was unmeasurable ($\ll 0.5$uU/ml) in approximately 15% of both females and males; in 95% the TSH concentration was less that 3.5 uU/ml and 5.2 uU/ml was the highest value observed.

Table 1B. — Normal Values for Thyroid Function Tests.

	T_4 ug/dl	T_3 ng/dl	rT_3 ng/dl	T_3U %	FTI
Mean	7.4	143	21.2	29.7	7.2
± 2 SD	5 - 9.8	91 - 215	11.2 - 31.2	23.9 - 35.5	5.0 - 9.4
Range	4.5 - 10.9	83 - 222	12.3 - 37	23 - 38.2	4.2 - 11

Table 2. — Values of Thyroid Function Tests in Normal Pregnant Women.

	T_4 ug/dl	T_3 ng/dl	T_3U %	FTI	TBG mg/L
n	255	135	135	135	100
Mean ± SD	10.9 ± 1.9	186 ± 28.8	16.7 ± 2.4	6.1 ± 1.1	54.5 ± 8.5
Range	6.1 - 16.3	131 - 254	11.4 - 23.5	3.8 - 9.7	32.2 - 69.9

A positive test for antithyroglobulin (≥ 1:10) was found with only five sera; all five were also positive (≥1:400) for antibody to the microsomal antigen. Therefore data for only the latter antibody are given (Table 5). Of all blood donors 10.7% were positive; the prevalence was higher in females (15%) than in males (5%). When the age distribution of subjects with positive antibodies was analyzed, 75% of males and 88% of females were in the younger age group (20-40 years) (Table 6).

Abnormal thyroid function tests were found in 8% of the blood donors (47 of 586 subjects) (Table 7). These were of three types of data, viz., low T_3U with high T_4 (all female, 12% of 336); high T_3U and low T_4 (four men, i.e., 1.6% of 250); one female and two males, all with serum positive for antibody to the microsomal antigen, had TSH above normal.

Discussion • The primary intent of this study was to establish normal values of thyroid function tests for a routine laboratory using sera from a group of blood donors. These are listed in Table 1. Analysis of the data showed significant differences between mean values of TT_4, TT_3 and T_3U in females and males although the differences were small and clinically irrelevant. This finding of statistical significance is a characteristic of analysis of large samples.[1] Similarly FT_4 and FT_3 differed between the two sexes, males having higher mean values while they had a TBG concentration significantly lower. The reason for the difference in free thyroid hormone concentrations is unknown, but it has been previously reported by analog T_4 RIA determination.[2] Furthermore, earlier studies described higher TBG levels in women than in men[3] and whether such findings can explain the differences in FT_4 and FT_3, or whether they are of physiological importance, is unknown.

Although the prevalence of abnormal thyroid tests in a general population is uncertain, in this report we call attention to the fact that 8% of 586 blood donors had one or more abnormality and that 10% had positive thyroid antibodies. As Tables 3 and 4 show, several alterations of thyroid function tests occurred. The abnormal serum total T_4 concentration and T_3U were in approximately 8% of subjects, the majority having an elevation of T_4 with a low T_3U and the rest a low T_4 and high T_3U. Although clinical data are missing for the accurate interpretation of these results, it is most likely that the alterations can be attributed to changes in TBG. All 40 subjects with elevated total T_4 and low T_3U were young females in whom an increase in TBG due to estrogen administration is highly likely. In contrast, in four men there was a low T_4 and high T_3U compatible with TBG deficiency. A low concentration of TBG occurs in several clinical syndrome such as hypoproteinemia,[4,5] androgen therapy,[6] or secondary to hereditary factors;[7] any of these causes may have been operative in the four men we identified.

Thyroid antibodies occur in the serum of patients with Hashimoto's thyroiditis or Graves' disease but also in patients with subacute thyroiditis,

Table 3. — Free Thyroid Hormone Concentrations and TBG in Blood Donors.

Subjects	FT_4 ng/dl	FT_3 pg/ml	TBG mg/L
Males	2.1 ± 0.4*	5.1 ± 0.9	25.8 ± 5.1
Range	1.24 - 2.56	2.98 - 6.44	18.3 - 46.1
n	35	27	99
Females	1.8 ± 0.2**	4.2 ± 0.7**	29.8 ± 5.8**
Range	1.2 - 2.42	2.5 - 6.3	18.9 - 47.2
n	109	107	132
Total	1.9 ± 0.3	4.4 ± 0.8	27.9 ± 5.8
Range	1.2 - 2.96	2.5 - 6.44	18.3 - 47.2
n	144	134	221

*Mean ± SD
**$p < 0.001$ males vs females

Table 4. — Serum TSH in Blood Donors.

	TSH (uU/ml)		
	0.5	0.6 - 3.5	3.6 - 5.2*
Males	32	176	7
n = 215	15%	82%	3%
Females	44	229	7
n = 280	15%	82.5%	2.5%
Total	76	405	14
n = 495	15.3%	82%	2.5%

*5% relative frequency

thyroid carcinoma or after thyroid surgery or therapy with radioiodine.[8] Previous studies on blood donors by Bjoro et al showed a prevalence of antibodies to thyroglobulin of 3.4% and to the microsomal antigen of 7.0%.[9] Similarly, we found 10.7% of blood donors with positive thyroid antibodies with the higher prevalence being in females and in the younger age groups (Table 5). There is evidence that the peak prevalence of thyroid antibodies reflecting autoimmune thyroid disease occurs between the age of

Table 5. — Prevalence of Thyroid Antibodies in 383 Blood Donors.

	n	%
Males	8	5
Females	33	15
Total	41	10.7

Table 6. — Age Distribution of Subjects with Positive Antithyroid Antibodies.

Blood Donors

	MALES			FEMALES			MALES + FEMALES		
Age Group	No.	Ab+ve	%	No.	Ab+ve	%	No.	Ab+ve	%
19-20	4	0	0	4	1	25.0	8	1	12.5
21-30	101	5	5.0	99	15	15.2	200	20	10.0
31-40	27	1	3.7	81	14	17.3	108	15	13.9
41-50	16	1	6.3	21	2	9.5	37	3	8.1
51-60	11	1	9.1	15	1	6.7	26	2	7.7
61-65	3	0	0	1	0	0	4	0	0
Total	162	8	4.9	221	33	14.9	383	41	10.7

Ab = Microsomal antigen Titer 1:1600 and up

Table 7. — Prevalence of Abnormal Thyroid Function Tests in 586 Blood Donors.

	Females	Males
Elevated T_4	40	0
with low T_3U	6.8%	0
Low T_4 with	0	4
elevated T_3U	0	0.7%
Elevated TSH*	1	2

*Individual results: 7uU/ml; 9.1 uU/ml and 14 uU/ml; all patients antithyroid antibodies positive.

50 to 60 years;[10] our finding of more positive results in the younger population may be attributable to the small number of older participants in this study.

It is generally accepted that the majority of the available techniques for the measurement of serum TSH have poor sensitivity for the lower limits of the normal range. In this study of euthyroid subjects we failed to detect TSH in 15.3% of subjects and the upper limit was approximately 3.5uU/ml (in 95% of subjects, Table 4). An elevation of serum TSH was seen in 0.5% of subjects and in these there were also positive thyroid antibodies. Since the serum TSH concentration is the most sensitive indicator of thyroid failure, it may be assumed that the mild elevation of serum TSH and positive antibodies in these patients represent subclinical hypothyroidism.

In conclusion our results in blood donors suggest that a comprehensive evaluation of thyroid function tests and a screening of thyroid antibodies are necessary to establish the normal range of values since 8% of presumably euthyroid subjects have abnormalities in routine tests.

Acknowledgment

J. M. Mckenzie, M.D. is a Kathleen and Stanley Glaser Professor of Medicine. This work was supported in part by USPHS Grant No. AM 31391.

References

1. Documenta Geigy — Statistical Methods, p. 195, Geigy Pharmaceuticals, Montreal, 1962.
2. Wilke, T.J.: Influence of Age and Sex on Concentration of Free Thyrozine in Serum and on Free Thyroxine: Total Thyroxine Ratio, Clin. Chem. 29:1428-1430, 1983.
3. Gershengorn, M.C.; Larsen, P.R., and Robbins J.: Radioimmunoassay for Serum Thyroxin-Binding Globulin: Results in Normal Subjects and Patients with Hepatocellular Carcinoma, J. Clin. Endocrinol. Metab. 42:907-911, 1976.
4. Levy, R.P.; Marshall, J.S., and Valeyo, N.L.: Radioimmunoassay of Human Thyroxine-Binding Globulin (TBG), J. Clin. Endocrinol. Metab. 32:372-381, 1971.
5. Gavin, L.A.; McMahon, F.A.; Castle, J.N., and Cavalieri, R.R.: Alterations in Serum Thyroid Hormones and T_4-binding Globulin in Patients with Nephrosis, J. Clin. Endocrinol. Metab. 46:125-130, 1978.
6. Federman, D.D.; Robbins, J., and Rall, J.E.: Effect of Methyltestosterone on Thyroid Function, Thyroxine Metabolism and Thyroxine-Binding Protein, J. Clin. Invest. 37:1024-1030, 1960.
7. Refetoff, S.; Robin, N.I., and Alper, C.A.: Study of Four New Kindreds with Inherited Thyroxine Binding Globulin Abnormalities: Possible Mutations of Single Gene Locus, J. Clin. Invest. 51:848-867, 1972.
8. Mori, T. and Kriss, J.P.: Measurement by Competitive Binding Radioassay of Serum Antimicrosomal and Anithyroglobulin Antibodies in Graves' Disease and Other Thyroid Disorders, J. Clin. Endocrinol. Metab. 33:688-698, 1971.
9. Bjoro, T.; Garden, P.I.; Simeland, E.B., and Kornstad, L.: Thyroid Antibodies in Blood Donors: Prevalence and Clinical Significance. Acta Endocrinol. 105:324-329, 1984.
10. Dingle, P.R.; Ferguson, A.; Harn, D.B.; Tubmen, J., and Hall, R.: Incidence of Thyroglobulin Antihodies and Thyroid Enlargement in General Practice in Northeast England, Clin. Exp. Immunol. 1:227-284, 1966.

● Dr. Banovac, University of Miami School of Medicine, Department of Medicine (R-93), P.O. Box 016760, Miami 33101.

Aberrant right subclavian artery as a cause of respiratory distress and dysphagia in an adult

Eduardo Chapunoff, M.D., F.A.C.P., F.A.C.C. and Irwin B. Boruchow, M.D.

ABSTRACT: A 27-year-old female presented with a long history of severe attacks of respiratory distress and dysphagia. The physical examination, ECG, chest x-ray and echocardiogram were normal. A barium esophagram disclosed a characteristic indentation due to an aberrant right subclavian artery. Esophageal-tracheal compression may be related to the concomitant existence of an abnormal origin of the carotid arteries. Following corrective surgery, the patient became asymptomatic.

In 1794 Bayford described the autopsy of a 62-year-old woman who was emaciated and had experienced dysphagia for 20 years. The esophagus was obstructed by an anomalous right subclavian artery. He termed the condition "dysphagia lusoria." The Latin word lusor means deceiver, a freak of nature.

In 1945 Gross first successfully divided the artery in an infant with good results.

This has been described as the most frequent anomaly of the aortic arch (.5 to 1% of population).[1] Usually it is asymptomatic. In symptomatic patients, a double aortic arch appears to be the most frequent abnormality. In childhood, an aberrant right subclavian artery can cause serious respiratory and swallowing difficulties. Adults, almost always, suffer from dysphagia alone.[2] This report describes the occurrence of dysphagia and respiratory distress in an adult with that abnormality.

Case report — A 27-year-old white female presented with a chief complaint of intermittent episodes of shortness of breath. She also gave a long history of difficulties in swallowing manifested by a feeling of food being stuck in the upper third of her chest. During infancy she "would choke and turn blue." During adolescence and adulthood she continued to have sporadic bouts of severe dyspnea, at times associated with moderate cyanosis. Dysphagia was a more frequent but generally less distressing symptom. She saw different physicians but a definitive diagnosis was never reached. During the week preceding admission to the hospital, she had alarming attacks of dyspnea. Her physical examination, ECG, chest x-ray and echocardiogram were normal. The barium esophagram (Fig. 1) showed a posterior indentation in the upper third of the esophagus. A retrograde aortogram confirmed an anomalous origin of the right subclavian artery originating from the descending thoracic arch. The two common carotids orginated from a single trunk.

The Authors
EDUARDO CHAPUNOFF, M.D., F.A.C.P., F.A.C.C.
IRWIN B. BORUCHOW, M.D.
Dr. Chapunoff is Associate Professor of Medicine, University of Miami School of Medicine and Dr. Boruchow is a cardiovascular surgeon, Department of Cardiology and Cardiovascular Surgery, St. Francis Hospital, Miami Beach.



Fig. 1. — Preoperative barium esophagram showing indentation in the upper third of the esophagus with severe constriction.

Because of the severe nature of the symptomatology, surgery was recommended. The right chest was opened through a 4th interspace incision. The aortic arch was on the left side. The subclavian artery was divided and an 8 mm Gortex graft was sutured end-to-end to the artery and end-to-side to the ascending aorta. The postoperative course was uneventful. Four years following surgery the patient remains asymptomatic and the barium esophagram is normal (Fig. 2).

Discussion • Vascular rings are aortic arch anomalies which may cause tracheal and esophageal compression. Clinically the three most important types are double aortic rings, right aortic arch with short left ductus arteriosus (ligamentum), and retroesophageal right subclavian artery. Patients with vascular rings are usually symptomatic during infancy and childhood with symptoms most frequently involving the respiratory tract. Dysphagia is less frequent. Respiratory manifestations include stridor, wheezing, cough, episodic choking, cyanosis, aspiration, respiratory infection and death by complications of respiratory obstruction.[3] The few symptomatic adults with an aberrant right subclavian artery nearly always complain of only dysphagia. Rarely, an arteriosclerotic aneurysm of an upper mediatinal shadow on the chest radiograph.[4] The anomalous right subclavian artery graph.[4] The anomalous right subclavian artery originates as the last branch of the aortic arch beyond the left subclavian artery and follows a left to right course to reach the right thoracic outlet. This situation usually produces no symptoms. On occasions, symptoms may be dramatic.[3] Klinkhamer[2] proposed that the combination of an aberrant right subclavian artery and an abnormal origin of the carotid arteries is required for occurrence of compression and production of symptoms. This may explain why the sole presence of the artery lying behind the esophagus and well fixed between



Fig. 2 — Postoperative barium esophagram showing resolution of the previously constricted area.

the rigid vertebral column behind and the trachea in front is enough in some cases to produce compressive symptomatology.[5]

Normally the innominate artery and the left carotid artery originate from the arch at a distance of about 4 cm from each other. Consequently, when an aberrant right subclavian artery presses the esophagus (and the trachea), this space is utilized; the esophagus and the trachea can bend forward and no compression occurs. However, when the two carotids are situated closer to each other or there is a common origin of the right and left carotid arteries (bicarotid truncus arteriosus, as in our patient), a V-like structure is formed and the trachea is prevented from bending forward. It is noteworthy that among 292 cases collected from the literature by Klinkhamer (76 publications), a bicarotid truncus arteriosus or a close origin of the carotids was found in 116 (36%) and symptoms and signs of tracheoesophageal compression were only present in these cases. This suggests that in the majority of symptomatic patients with an aberrant right subclavian artery the described abnormal disposition of the carotids would be responsible for the compressive symptomatology. The reasons for the episodic nature of the symptoms, however, are far from clear.

The simplest way of reaching a diagnosis is by barium esophagram which shows a characteristic oblique posterior indentation in the upper third of the esophagus (Fig. 1). More precise information on aortic vascular rings can be obtained by angiographic procedures (conventional arteriography and intravenous digital subtraction angiography.[6,7]

Division of the artery is indicated in symptomatic patients. In infants, delays have led to catastrophes.[3] In children, division of the artery is all that is required; however, in adults, reestablishment of blood flow to the subclavian artery is the treatment of choice.[8] Transection of the subclavian artery in the adult without reimplantation in the aorta can lead to ischemic right upper extremity symptoms and a subclavian steal syndrome of varying severity.[9] The case presented indicates that adults with an aberrant right subclavian artery may have severe attacks of dyspnea. It also suggests that long standing paroxysmal attacks of respiratory distress and dysphagia associated with normal physical examination, electrocardiogram and chest x-ray should invite the exclusion of a vascular ring abnormality, of which, in the adult, an aberrant right subclavian artery would be the most likely cause.

References

1. Fontana, R.S. and Edwards, J.E.: Congenital Cardiac Disease. Review of 357 Cases Studied Pathologically, Philadelphia and London, W.B. Saunders Company, 1962, pp. 124-133.
2. Klinkhamer, A.C.: Aberrant Right Subclavian Artery: Clinical and Roentgenologic Aspects, AM. J. Roentgenol. Radium Ther. Nucl. Med., 97:438-446, 1966.
3. Lasher, E.P.: Types of Tracheal and Esophageal Constriction Due to Arterial Anomalies of Aortic Arch, with Suggestions as to Treatment, Am. J. Surg. 96:228-234, 1958.
4. Stoney, W.S.; Alford, W.C.; Burrus, G.R., et al: Aberrant Right Subclavian Artery Aneurysm, Ann. Thor. Surg. 19:460-467, 1975.
5. Shumacker, H.B., Jr.; Isch, J.H., and Finneran, J.I.: Unusual Case of Dysphagia Due to Anomalous Right Subclavian Artery, J. Thorac. Cardiov. Surg. 61:304-308, 1971.
6. Tonkin, I.L.; Elliot, L.P., and Bargeron, L.M., Jr.: Concomitant Axial Cineangiography and Barium Esophagography in Evaluation of Vascular Rings, Radiology, 135:68-76, 1980.
7. Moodie, D.S.; Yiannikas, J., Gill, Carl C., et al: Intravenous Digital Subtraction Angiography in Evaluation of Congenital Abnormalities of Aorta and Aortic Arch, Am. Heart J., 104:628-634, 1982.
8. Pifarre, R.; Dieter, R.A., and Niedballa, R.G.: Definitive Surgical Treatment of Aberrant Retroesophageal Right Subclavian Artery in Adult, J. Thorac. Cardiov. Surg. 61:154-159, 1971.
9. Pifarre, R.; Dieter, R.A., and Niedballa, R.G.: Definitive Surgical Treatment of Aberrant Retroesophageal Right Subclavian Artery in Adult, J. Thorac. Cardiov. Sug. 61:154-159, 1971.

● Dr. Chapunoff, 2301 Collins Avenue, M-103, Miami Beach 33139.

Computerized tomography and electroencephalography in childhood coma: which test should be performed first?

Israel Alfonso, M.D., Richard G. Curless, M.D., Bernard H. Holzman, M.D., Arturo J. Aballi, M.D., Cosimo Ajmone-Marsan, M.D., Ivette Caram, M.D., and Pedro F. Lopez

ABSTRACT: The evaluation of the comatose child often requires use of computerized tomography of the brain and electroencephalography. The results of CT scans of the brain in 56 and EEGs in 44 patients were reviewed to determine their value and the order in which they should be performed. We suggest that when both tests are being considered on a given patient the CT scan should precede the EEG in patients with head trauma and in those whose etiology has not been established and that the EEG should precede the CT scan in patients with an established etiology for coma other than head trauma.

The Authors
ISRAEL ALFONSO, M.D.
RICHARD G. CURLESS, M.S.
BERNARD H. HOLZMAN, M.D.
ARTURO J. ABALLI, M.D.
COSIMO AJMONE-MARSAN, M.D.
IVETTE CARAM, M.D.
PEDRO F. LOPEZ
Dr. Alfonso, a pediatric neurologist, is Vice-Chairman of Pediatrics at Hialeah Hospital; Dr. Curless is head of Pediatric neurology, Dr. Holzman is Director of the Pediatric Intensive Care Unit, Dr. Aballi is Director of Medical Education, and Dr. Ajmone-Marsan is Director of Electroencephalography at Jackson Memorial Hospital, University of Miami; Dr. Caram is a Pediatric Resident at the University of Missouri, and Mr. Lopez is a medical student at the University of Miami.

Evaluation of the comatose child often requires the use of computerized tomography of the brain and electroencephalography. The purpose of this study is to determine the order of these tests.

Methods and results • There are many definitions of coma[1,2] but for the purposes of this study it is defined as a state of altered mental status with a severe deficit of the arousal mechanism. In this study all patients had an acute or subacute onset of sleep-like state. They were either unarousable to deep painful stimuli or, if aroused, were confused and drifted back to a sleep-like state when the stimulus was discontinued. None were aroused by verbal stimulation.

One hundred one comatose children aged five weeks to 15 years hospitalized consecutively in Jackson Memorial Hospital from June 1979 to April 1982 constituted the study population. The distribution according to age groups was as follows: one to 12 months, 26 patients; 12 to 26 months, 27 patients; 36 to 72 months, 22 patients, and 72 months to 15 years, 26 patients. There was a male predominance of 56 vs 45 with twice as many males having suffered head trauma. The most frequent cause of coma was head trauma followed by metabolic disorders and poisoning (Table 1). Intracranial infection was found in 14% of our nontrauma patients. Seven patients had no established etiology after a thorough clinical and laboratory examination which included a spinal tap. After a CT and/or an EEG the etiology was established for all but one of these seven.

The patients were divided into four groups according to the initial neurological examination performed by a pediatric neurologist, neurosurgeon or a

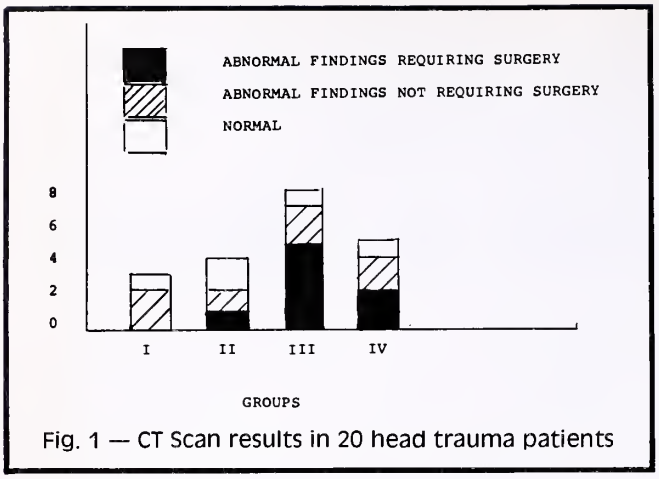


Fig. 1 — CT Scan results in 20 head trauma patients

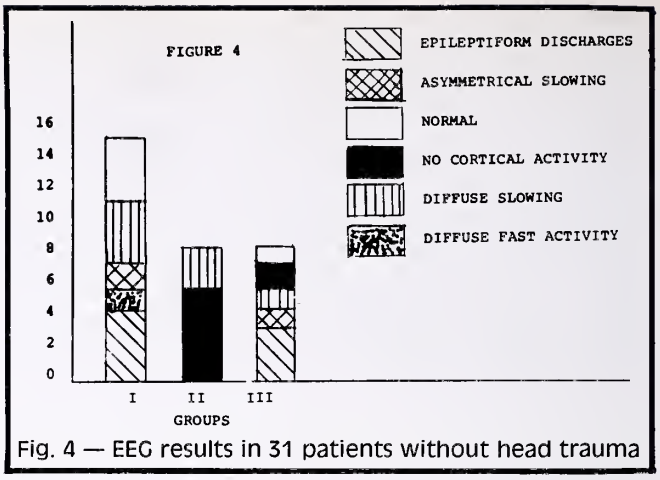


Fig. 4 — EEG results in 31 patients without head trauma

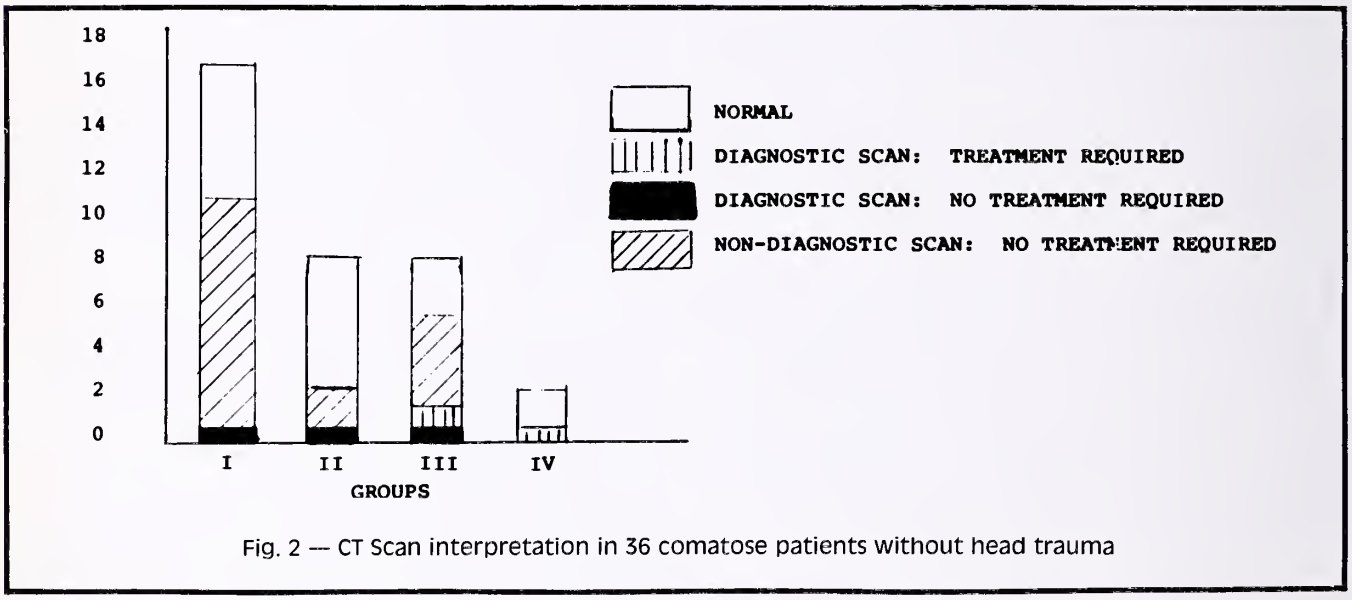


Fig. 2 — CT Scan interpretation in 36 comatose patients without head trauma

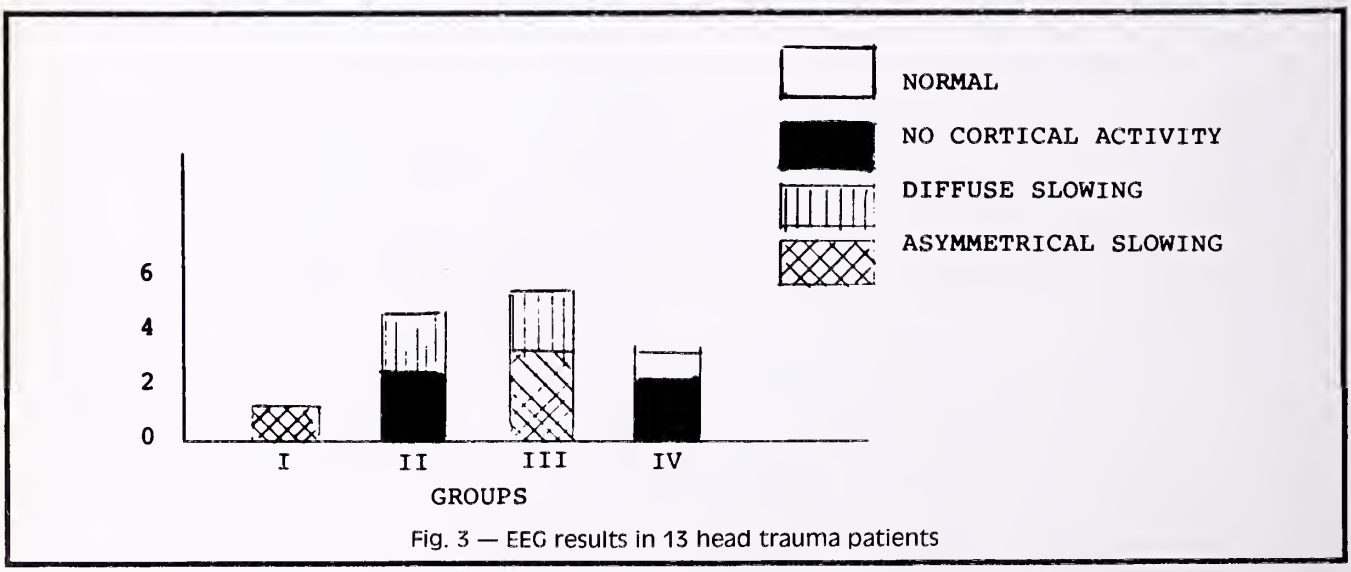


Fig. 3 — EEG results in 13 head trauma patients

Table 1.—Etiologic Diagnosis of 101 Comatose Patients and Correlation to the Neurological Classification

	Total	I	II	III	IV
Metabolic	23				
Hepatic	8	5	3		
Renal	4	2		2	
Endocrine	2	2			
Fluid and Electrolyte	7	7			
Other	2	1	1		
Trauma	24	4	6	8	6
Poisoning	13	12	1		
CNS Infection	11				
Bacterial	5	3		1	1
Viral	6	4		2	
Cardiorespiratory Arrest	8	2	3	3	
Septicemia	7	5	2		
Near Drowning	6	1	5		
Cerebral Vascular Accident	3	1	1	1	
Seizure	3	2		1	
Intracranial Tumor	2			1	1
Unknown	1	1			
	101	52	22	19	8

Table 2.— Groups According To Neurological Examination.

Groups	Brainstem Deficit	Supratentorial Lateralization
I	0	0
II	+	0
III	0	+
IV	+	+

pediatric intensivist. The groups were determined by the presence or absence of brainstem abnormalities and or lateralizing cerebral deficits (Table 2). The relation between the different etiologies and the neurological classification is shown in Table 1. The results of the CT scans in 56 patients and EEGs in 44 were considered in the light of this classification as well as two major etiological subdivisions: traumatic and nontraumatic. Figures 1 and 2 correlate the CT scan results with the need for therapy in trauma and its contribution to the etiological diagnosis in nontraumatic coma patients. Figures 3 and 4 indicate the EEG findings based on the same premises in these same two categories (trauma vs nontraumatic coma). All these figures are also correlated with the neurological classification.

Discussion • The diagnostic capability of the CT in the evaluation of head trauma cannot be overemphasized.[3-5] Of 24 patients with head trauma, 20 had CT scans (Fig. 1) eight required surgery. Of the four groups, patients in group III required surgery more frequently. Though none of the patients in group I required surgery, in two of the three surgery was considered as a therapeutic measure. Their CT scan did not alter managemnt of 15 patients with an established etiology; it was diagnostic in 5 of 7 patients without one.

EEGs did not alter management of the comatose head trauma patient except in cerebral death determination (Fig. 3). The EEG was very useful in the evaluation of the nontraumatic comatose patient (Fig. 4). Epileptiform activity was present in seven of 31 patients in this group. In contrast to the CT scan the EEG was most valuable in those patients with an established etiology. Epileptiform activity was detected in six of the 26 of these patients while only in one of the seven patients whose etiologic diagnosis had not been established.

In summary we believe that a CT scan should be performed prior to the EEG in patients with head trauma and on those with an undetermined etiology for the comatose state. The EEG should precede the CT scan in nontrauma patients with an established etiology. The neurological examinations were not a good indicator as to which should be performed first.

Acknowledgement

The authors would like to thank Ken Kitchens, Charlete Caleniri and Marta Cusculluela for their assistance in preparing this manuscript.

References

1. Plum, F., and Posner, J.B.: Diagnosis of Stupor and Coma, Ed. 3, Contemporary Neurology Series, F.A. Davis Company, Philadelphia, 1980, p. 5.
2. Johnston, R.B. and Mellits, E.D.: Pediatric Coma; Prognosis and Outcome, Develop. Med. Child Neurol. 22,3-12, 1980.
3. Zimmerman, R.A.; Bilaniuk, L.T.; Genneralli, T., et al.: Cranial Computed Tomography in Diagnosis and Management of Acute Head Trauma, AJE 131:27, 1978.
4. Davis, K.R.; Taveras, J.M.; Roberson, G.H., et al.: Computed Tomography in Head Trauma, Semin Roentgenol. 12:53, 1977.
5. deVillasante, Merino, III and Tevetas, M.M.: Computerized Tomography (CT) in Acute Head Trauma, AJR 125:765, 1976.

• Dr. Alfonso, Vice Chairman of Pediatric — Hialeah Hospital, 777 East 25th Street, Suite 419, Hialeah 33013.

THE CHANGING PRACTICE OF MEDICINE

The changes are all around us. New HMO's. Increasing numbers of medical school graduates. Pyramiding patient insurance headaches. Lack of dedicated personnel. Increasing malpractice suits and premiums.

This is a special invitation for you to Aim High as a member of the Air Force Health Care Team.

One of the advantages you would enjoy with us is time. Time for your patients. Time to keep professionally current. Time to relax. 30 days of vacation with pay each year.

Another advantage is peace of mind—financial security now, and a generous retirement if you qualify.

Leave the administrative hassles to others. Find out about an Air Force practice by calling me in complete confidence.

Major Ron Bailey
(305) 494-2728

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

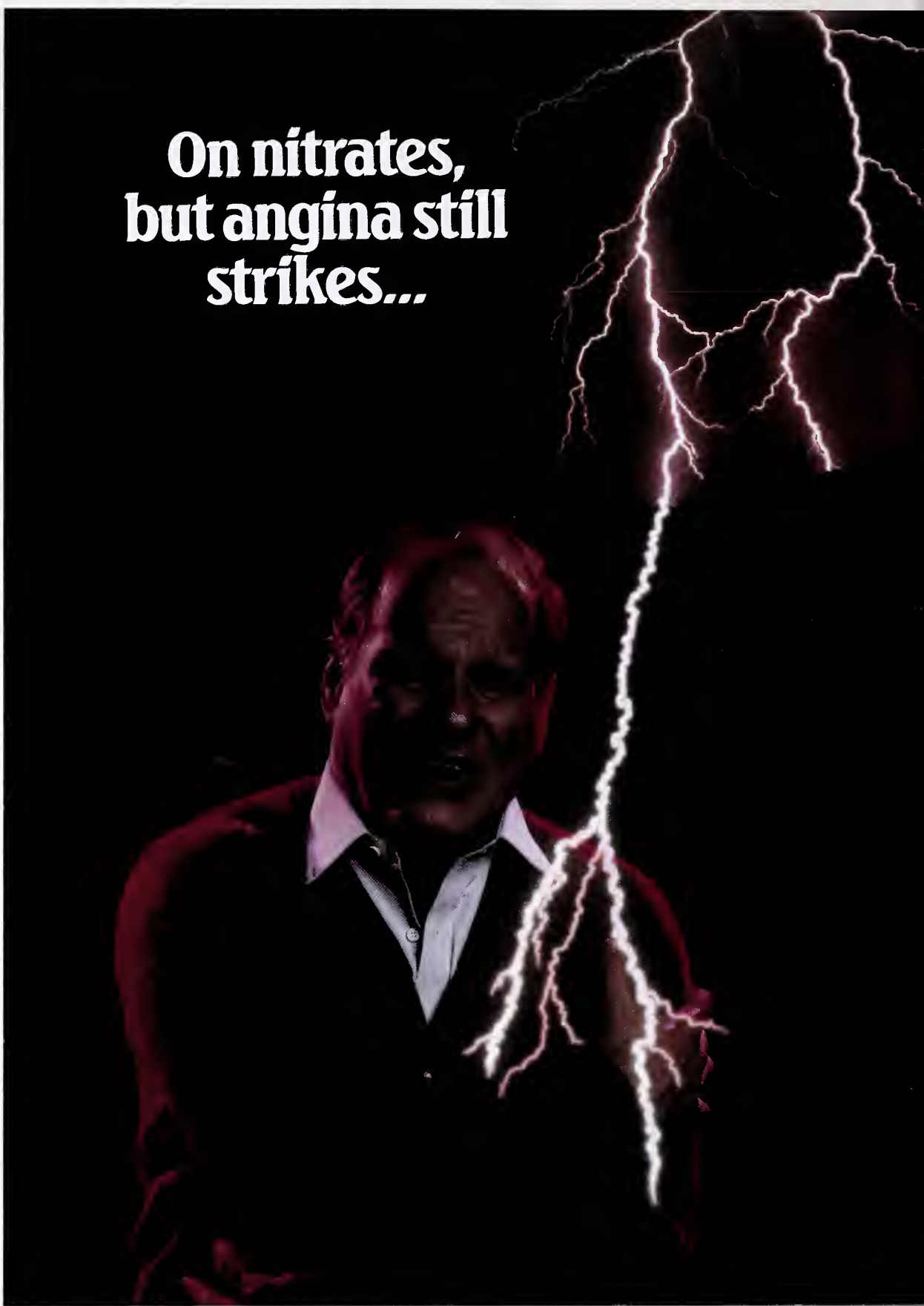
Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.
JUST ASK THE PEOPLE AT GEORGIA-PACIFIC.

"For me, buying Savings Bonds is an efficient way to save for a rainy day."
—Laura Schafer



"Savings Bonds allow me to put some money away before I get a chance to spend it."
—Rick Crews

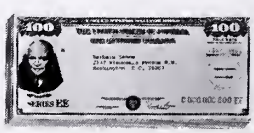


"Besides being a good investment in my country, Bonds help me save for my two daughters."
—Craig Heimbigner



U.S. Savings Bonds now offer higher, variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

SPECIAL ARTICLES

Present status of scoliosis screening in Florida schools

Joseph C. Flynn, M.D., Max F. Riddick, M.D., Charles T. Price, M.D., and Thelma L. Keller, P.T.

ABSTRACT: Statewide screening of Florida school children for early detection of spinal deformity is now established in grades 6 to 9. In three years, nearly a half million (496,965) examinations have been done. The incidence of possible spinal curvatures in these children is 6% (32,368). Our history of screening is recounted. The errors and pitfalls have been located and discussed. The routine screening of Florida school children for spinal deformity is practical and effective.

The Authors
JOSEPH C. FLYNN, M.D.
MAX F. RIDDICK, M.D.
CHARLES T. PRICE, M.D.
THELMA L. KELLER, P.T.
Dr. Flynn is Medical Director of the Florida Elks Harry-Anna Crippled Children's Hospital at Umatilla; Dr. Riddick is in private practice with the Jewett Orthopaedic Clinic in Winter Park; Dr. Price is a pediatric orthopaedic surgeon in private practice in Orlando; and Ms. Keller is a physical therapist in private practice in Orlando.

The advantage of early detection of spinal deformity in growing children is that it can often be arrested before becoming severe. At the least, this will spare the child a serious, painful and expensive operation and, at the most, a lifetime of compromise because of appearance, limited function and pain.

History of scoliosis screening in Florida • The routine examination of school children for spinal deformity (scoliosis screening) originated nearly 20 years ago in Delaware and has been successful in virtually eliminating the need for surgery for idiopathic scoliosis in that state.[1]

Scoliosis screening in Florida began with a pilot program in Orange County schools in 1975.[2] This program was supported by the Citrus Orthopaedic Society and Florida Orthopaedic Society and had the approval of the Orange County Medical Society. Primary screening was done by physical education teachers who had been trained by an orthopaedist-physical therapist team. Secondary screening was done by volunteer orthopaedic surgeons of the Citrus Orthopaedic Society. The idea quickly spread to surrounding counties and with the help of the Florida Orthopaedic Society to more remote counties. Doctors, nurses, physical therapists, parents, and school authorities in numerous counties cooperated to spread screening across the length and breadth of Florida.

It became evident that a statewide program, to be a reproducible model year after year in all 67 counties, could not depend on volunteer orthopedists (some counties had few or none). We turned to Citrus and Hernando Counties where the school or county health nurse replaced the doctor. The suc-

cess of the program in those two counties served as a further model that would be practical for all 67 counties.

Meanwhile, the School Health Advisory Committee of the Florida Medical Association gave its support to scoliosis screening. This Committee is composed of physicians and key personnel from the Department of Health and Rehabilitative Services in School Health and Family Health as well as personnel from the Department of Education.

In 1979 the Florida legislature mandated scoliosis screening for the early detection of spine deformity in Florida school children.

The Health and Rehabilitative Services Committee of the Florida House of Representatives studied the need for scoliosis screening by questioning medical witnesses and reviewing the pilot Orange County program. Individual legislators responded to the request of Florida Orthopaedic Society and Florida Medical Association members by introducing and supporting the necessary amendment.

In 1979 the Florida legislature mandated scoliosis screening for the early detection of spine deformity in Florida school children. Section 402.32, Florida Statutes, 1978 Supplement, was amended on July 1, 1979 to read: "School Health Services Program. . .(5) Each District School Board and the Department of Education where applicable shall have the duty of: (f) To examine each public school child, at the proper age, for scoliosis." In 1980 the legislature included private schools in the mandate for scoliosis screening.

Ten year screening statistics for Orange County are shown in Table 1. The screening was done in 20 junior high schools, grades 7 to 9. In the first four years suspected curves were seen in 1.6% of students screened. In the next six years, 2.4% were referred with suspected scoliotic curves. The ratio of girls to boys was 2:1. Orthopaedic surgeons screened for the first seven years. Nurses have screened since 1982. Note that the number of suspected curves rose sharply nearly doubling the first year, then gradually declined as nurse-screeners gained more experience. The number of cases under treatment is not recorded until 1979. Note that the number is steadily decreasing and the ratio of girls to boys is approximately 4:1.

The initial statewide screening was done in the appropriate junior high schools, grades 7, 8 and 9 or grades 6, 7 and 8 in those counties with middle schools. The first year of statewide screening in 1979 to 1980, 49 of 67 counties reported 70,503 children screened with 5,664 (8%) referred for evaluation for possible scoliosis; 1,571 (2%) were placed under treatment or observation (Table 2).[3,4]

Statistics for 1981-82 reporting by district (1 to 11) rather than county (Table 3) showed that 235,131 children were screened. Of these, 5% (11,835) were referred for examination and 87% (10,271) completed the evaluation by a physician.

For 1982-83, our third year of screening, (Table 4) 191,331 children were screened. The nurse-screener referred 8% (15,272) for further examination; 15,176 completed the suggested examination by a physician. Unfortunately, we do not have statistics of numbers requiring treatment by observation, brace or surgery.

We are now in our fourth year of statewide screening and state officials are considering streamlining the screening program by selecting one grade, i.e., grade 6 or 7.

Table 5 shows the number of children in various grades 6 to 9 across the state. We believe that screening should continue in 7th and 8th grades (ages 13 and 14) and in those counties having junior high schools. Likewise, it should continue in grades 6 and 7 in those counties having middle schools. If, however, we were forced to select one grade only, it would be the 7th grade. Seventh graders are between

Table 1. — Scoliosis Screening Statistics, Orange County Schools*

YEAR	NUMBER SCREENED	REFERRED Number	REFERRED Percent	Girls	Boys	TREATMENT** Girls	TREATMENT** Boys	NON PARTICIPANTS
1975-1978	64,906	1,086	1.6	746	340	—	—	—
1979	15,188	138	0.9	94	44	71		—
1980	16,880	355	2.1	243	112	97	35	252
1981	16,366	264	1.6	188	76	88	28	380
1982	16,376	619	3.7	384	235	61	14	297
1983	14,636	524	3.5	341	183	78	8	394
1984	13,299	383	2.8	246	137	62	13	411

*20 schools screened grades 7-9

**Observation, lateral electrical spine stimulation, brace, surgery

Table 2. — Florida Screening 1979-80, Grades 6-9, 49 of 67 Counties.

	Total
Screened	70,503
Number Referred	5,664 (8%)
Number Treated	1,571 (2%)

Table 3. — Florida Screening 1981-82, Grades 6 to 9, 11 Districts, 67 Countries.

Screened	235,131
Referred	11,835 (5%)
Completed	10,271

12 and 13 years of age and have two or more years of skeletal growth ahead of them.[5] Discovery of scoliosis in these children will usually "catch" it in time to employ a brace to control or prevent progression of the spinal deformity.

Recommendations for primary care physicians • The primary care physician (family practitioner or pediatrician) should carefully examine the child's back for scoliosis and kyphosis as outlined in Figures 1-3. If he feels scoliosis or kyphosis is significant, he obtains an x-ray. Scoliotic or kyphotic x-ray should be a 14 x 7 standing anteroposterior or lateral thoracolumbar spine. A standing x-ray is the one necessary to diagnose the deformity and document the amount of the curve. A supine x-ray would be inadequate. If significant scoliosis or kyphosis is detected, the child should be referred to an orthopedist either as a private patient or to local Children's Medical Services Clinic or one of the free children's hospital screening clinics such as the Florida Elks Children's Hospital at Umatilla, Nemours Children's Hospital at Jacksonville, Shriners Children's Hospital at Tampa, All Children's Hospital, St. Petersburg or Variety Children's Hospital in Miami.

Problems Encountered • 1. Sheer Numbers of Positive Examinations: Our screening nurses are trained to detect a rib or lumbar hump and they have indeed become quite skilled and conscientious in detecting these humps, hence the large number of children presenting for examination. We have no easy and inexpensive way to separate children with minor curves from those with major curves except for examination by the physician and eventually an x-ray. However, after the first x-ray examination, a curve may be followed by observation of the size and/or angle of inclination of the hump. Bunnell from the Nemours Children's Hospital in Wilmington, Delaware has perfected a specially designed inclinometer that measures the angle of trunk rotation represented by the hump. The method is simple, reliable and inexpensive and is easily taught to lay personnel in scoliosis screening. It shows promise of eliminating a large number of false positives.[6]

2. Failure of Parents to Follow Through with Recommendation to Report to Physician: This happens for reasons of ignorance, fear and inability to afford a private physician. In our first year of screening in Orange County, we sent a postcard home to the parents hand carried by the child. This was a mistake; many of the children never delivered the card. We solved the problem by mailing the cards.

Ignorance and fear can be countered by communication, transmitting the scoliosis information to the parent by printed material, emphasizing the possible complications and need for early care. Free scoliotic screening is offered by county health physicians, Children's Medical Services and the various children's hospitals.

Ignorance and fear can be countered by communication, transmitting the scoliosis information to the parent by printed materail, emphasizing the possible complications and need for early care.

3. Failure of Primary Physician to Advise the Family Properly: He may ignore the referral and dismiss the child without examination. If a rib hump is found, it may be downgraded in importance as being of little consequence.

4. Failure to Obtain Adequate X-Ray: The primary care physician may fail to order an x-ray or may obtain a supine film which fails to show the real amount of curve.

Table 4. — Florida Screening 1982-83, Grades 6-9, 11 Districts, 67 Counties.

	Total
Number	191,331
Referred	15,139 (8%)
Completed	15,176*

*Includes some carry-overs from last year who completed referral.

Table 5. — Number of Students Eligible for Scoliosis Screening - 1984.

Grade 6	213,959
Grade 7	125,582
Grade 8	118,664
Grade 9	122,456
TOTAL	580,661



Fig. 1 — A classic rib hump seen from posterior as scoliotic patient bends forward with fingertips and palms together.



Fig. 2 — The same rib hump as Figure 1 viewed from anterior.

PROCEDURE:

Screener: Sit a few feet in front of the tape mark which was placed on the floor. Place Scoliosis Screening Report Forms on a table next to screener.

If necessary, throughout the screening, remind the student to *stand erect*, neither "at attention" nor slouching. Stand with *feet together, knees straight, arms* held *relaxed at sides*.

Student: Enter

✓ Name on Class Roll

1. FACE SCREENER
 - a) Stand erect
 - b) Bend forward – Palms together



1a) ✓ High shoulder
✓ Uneven hips
✓ Unequal arm to body spaces

b) ✓ Rib hump
✓ Uneven contour

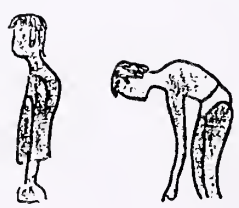
2. BACK TO SCREENER
 - a) Stand erect
 - b) Bend forward – Palms together



2a) ✓ High shoulder
✓ Curved spine
✓ Uneven shoulder blades
✓ Uneven hips or waist creases
✓ Unequal arm to body spaces

b) ✓ Rib hump
✓ Lumbar (flank) hump
✓ Uneven contour

3. TURN LEFT SIDE TO SCREENER
 - a) Stand erect
 - b) Bend forward – Palms together



3a) ✓ Excessive swayback
Guide: Refer if it prevents bending forward and touching ankles.
✓ Excessive roundback

b) ✓ Unusual contour or hump
(Normal: Smooth, rounded curve)

Fig. 3 — Procedure for school scoliosis screeners.

Reprinted with permission from "Screening for Scoliosis in Florida Schools" published by the Florida Orthopaedic Society, 1981.

5. Failure to Appreciate Progression of Curve on Followup: This is a common error in treating scoliosis. Either inaccurate measurements are made or comparison with previous x-rays is not done. Unfortunately the orthopedist may be as guilty as the primary care physician on this one. This may be remedied by careful comparison of successive films at four month intervals in growing children with scoliosis.

6. Incomplete Statistics: From the schools, we need additional information from the postcard filled out by the physician on numbers of children confirmed to have scoliosis and type of treatment begun (observation, brace, L.E.S.S.* or surgery).

From the treating physicians we need to know the etiology of the scoliosis, its curve pattern and its magnitude as well as treatment elected. Such information is difficult to obtain statewide from busy physicians. We hope to solve this with a simplified computer card form to go with each positive child.

Training films are available to those responsible for screening and/or training new screening personnel: Spinal Screening Program (Scoliosis Research Society), Scoliosis Screening for Early Detection (Gillete Children's Hospital), and School Screening for Scoliosis (slide cassette training for screener). Contact the Florida Orthopedic Society, Scoliosis Screening Committee, Post Office Box 18564, Tampa 33679.

*Lateral Electrical Spine Stimulation

Acknowledgment

The authors wish to acknowledge the invaluable contribution of Mr. Jim Vickers to the development of the Orange County Pilot Program.

References

1. Hensinger, R.N.; Cowell, H.E.; MacEwen, G.D.; and Shands, A.R., Jr.: Orthopaedic Screening of School Age Children, Review of 10 Year Experience, Ortho. Rev. IV: 23-28, 1975.
2. Flynn, J.C.; Riddick, M.F., and Keller, T.L.: Screening for Scoliosis in Florida Schools, JFMA 64:159-161, 1977.
3. Florida Department of Health and Rehabilitiative Services, Health Program Office, Personal communication, August 1984.
4. Tolliver, J.W., Human Services Program Analyst, Maternal and Child Health Program Office, Personal communication, August 1984.
5. Lonstein, J.E. and Carlson, J.M.: Prediction of Curve Progression in Untreated Idiopathic Scoliosis During Growth, JBJS 66-A: 1061-1071, 1984.
6. Bunnell, W.P.: Objective Criterion for Scoliosis Screening, JBJS 66A: 1381-1387, 1984.

- Dr. Flynn, 1315 South Orange Avenue, Suite 2D, Orlando 32806-2197.

The cost of no prenatal care

Walter J. Morales, M.D., Ph.D., Betty J. Vaughn, M.D., N. Donald Diebel, M.D., Ph.D.

> No cold statistic expresses more eloquently the difference between a society of sufficiency and a society of deprivation than the infant mortality rate. K. Newman, Infant Mortality and the Health of Society

Perinatal mortality rates in the United States have experienced remarkable declines over the past 35 years, from 39.7/1000 live births in 1950 to 29.3 in 1970 to 17.7 in 1980,[1] undoubtedly a reflection of continued advances in fetal-maternal and neonatal medicine. Nevertheless, as our 17th place ranking indicates, the perinatal mortality rate in this country substantially exceeds that of other industrialized nations.[2]

The data indicate that although low birth weight (LBW) infants weighing less than 2,500 grams constitute less than 10% of the total neonatal population, they account for up to 75% of the perinatal mortality.[3] Therefore, improved neonatal outcome can only be accomplished through a reduction in the rate of prematurity.

The results of a recent study[4] completed at Orlando Regional Medical Center involving 488 very low birth weight (VLBW) infants are summarized in Table 1. All infants were under 1,500 grams and gestational age less than 33 weeks and were delivered over the four year period 1981 through 1984. The data demonstrate the remarkable inverse relationship between birth weight and neonatal mortality, length of stay in the neonatal ICU, and neonatal ICU cost. Further, the data show that indeed for gestations between 26 and 33 weeks, each day lost of intrauterine life resulted in three days of neonatal ICU care. Moreover, for each ten days of additional intrauterine life, neonatal mortality was decreased by about 50%, thus demonstrating that in spite of great technological achievements in neonatal medicine, "maternal ICU" is still in general the superior environment for the immature fetus. Therefore, once more it must be emphasized that if one is to achieve substantial reduction in the perinatal mortality rate, it is imperative that the rate of prematurity be decreased.

Creasy and associates[5] demonstrated that the rate of prematurity could be reduced through an intensive program of patient education regarding the subtle signs of premature labor, identification of those patients at risk for prematurity and the aggressive managment of premature labor. From the efforts of this study evolved the Creasy protocol adopted by prenatal care clinics in Florida in 1983.

While the Orange County Health Department (OCHD) actively screens and evaluates each patient enrolled in its prenatal clinics for risks of premature delivery and possible referral to the High Risk Obstetrical Clinic (HROC) for more extensive monitoring, restricted funding has resulted in the exclusion of patients with a gross income exceeding poverty level: $4,980 single patient through $10,200 for a family of four.

Despite a 30% population growth in Orange County over the past eight years, the number of

The Authors
WALTER J. MORALES, M.D., Ph.D.
BETTY J. VAUGHN, M.D.
N. DONALD DIEBEL, M.D.
Drs. Morales, Vaughn and Diebel are with the Department of Obstetrics and Gynecology at Orlando Regional Medical Center, Inc., Orange County Health Department, Orlando.

Table 1. — Outcome of Very Low Birth Weight Infants.

	WEIGHT			
	≤800 gm	801-1000 gm	1001-1200	1201-1500
Number VLBW Babies	74	96	124	194
Average Gestational Age (weeks)	27	28	30	31
Mortality No(%)	49(66)	26(27)	18(15)	9(5)
Average Hospital Days in NICU	115	72	64	49
Average Cost Per Surviving Infant	$105000	$52000	$39000	$27000
Intraventricular Hemorrhage (%)	78	66	35	25
Respiratory Distress Syndrome (%)	62	60	48	35

obstetrical patients served by the OCHD clinics has been reduced by 50% as a result of budgetary restrictions.

The purpose of this study was to quantitatively establish the cost/benefit effects of the current health care policies and to propose alternatives.

Materials and methods • Over the two year period January 1983 through December 1984, there were 10,011 deliveries at Orlando Regional Medical Center, a tertiary care facility serving Central Florida, and of these 994 (10%) received no prenatal care. Of the 9,017 patients who received prenatal care, 6,220 (69%) were managed by private attending physicians, 2,432 (27%) were followed at the OCHD and 365 (4%) at the HROC. The outcomes of these pregnancies were studied in terms of incidence of premature births (LBW and VLBW infants), rates of stillbirth, neonatal mortality and neonatal care costs, to establish a quantitative effect of limiting prenatal care.

The data were analyzed by means of the Chi-square and the Student t-tests. Differences were considered significance at a .05 level.

Results • The race, age and parity distributions of these groups of patients are shown in Table 2. The medical complications of those patients followed at the HROC are summarized in Table 3.

Table 4 summarizes the outcome of these pregnancies. As shown, the incidence of LBW and VLBW infants was significantly higher in the group of patients with no prenatal care, 34% vs 8% and 13.5% vs 1.5% respectively, statistically significant at $p < .001$. Furthermore, although dealing with patients with significant medical complications predisposing to premature birth and poor pregnancy outcome, the rate of prematurity among patients receiving prenatal care at the HROC, 13% LBW and 2.7% VLBW, was considerably less than the group with no prenatal care.

Table 2. — Characteristics of Patients.

	PRENATAL CARE			
	None	Private	OCHD	HROB
Number of Patients No(%)	994(10)	6220(62)	2432(24)	365(4)
Teenage Pregnancies No(%)	206(21)	217(3)	730(30)	55(15)
Primigravida No(%)	278(28)	1866(30)	806(33)	88(24)
Race				
Caucasian No(%)	606(61)	5474(88)	1265(52)	201(55)
Noncaucasian No(%)	388(39)	746(12)	1167(48)	164(45)

Lack of prenatal care also resulted in a substantial increase in the rates of neonatal mortality and stillbirth, 32.2 and 26.2/1000 live births respectively, when compared to those with prenatal care, 3.54 and 9.5/1000 live births, statistically significant at $p < .001$. Similarly, the average neonatal cost per surviving infant in the group receiving no prenatal care was $5,080 as compared to $760 in the patients whose mothers had received prenatal care, $p < .001$.

Discussion • The results from this two year study involving 10,011 patients demonstrate that lack of prenatal care resulted in a fourfold increase in premature births and fivefold increase in perinatal mortality. Even when compared to a group of 365 patients with significant medical complications, the group without prenatal care had substantially worse pregnancy outcomes, thus indicating that, indeed, lack of prenatal care is the single most significant adverse parameter affecting pregnancy.

The results from this two year study involving 10,011 patients demonstrate that lack of prenatal care resulted in a fourfold increase in premature births and fivefold increase in perinatal mortality.

The rising cost of medicine has understandably resulted in a limitation of funds available for obstetrical and neonatal care. However, aside from the ethical and moral considerations associated with the parental grief from poor pregnancy outcomes, factors never to be minimized by health care providers, the cost-benefit consequences of the current policy of limiting prenatal care funds can be quantitatively estimated. Neonatal ICU care based on 1983 costs resulted in an expenditure of $5,916,000 in the group of patients without prenatal care. The average cost of providing prenatal care in the OCHD clinics in 1983 and 1984 was $550/patient. Thus, $546,700 would have been required to provide obstetrical care to 994 "walk-in" patients who delivered at Orlando Regional Medical Center with no prenatal care. Since based on the outcomes of patients receiving prenatal care, it would have been expected that 1.3% of live born infants would have required neonatal ICU care at an average cost of $44,150/patient; the approximate total medical cost, had prenatal care been provided to the 994 patients, would have been $1,117,000. Thus failure to provide initial funds for prenatal care resulted in an overall net additional cost of $4,798,000 in this one center alone.

One may also note that the difference in the average neonatal cost between the group with no prenatal care and those with was about $4,000. Thus failure to spend $550 for maternal care resulted in $4,000 spent in neonatal care, i.e., for each dollar not spent for prenatal care, $7 are added to the total prenatal expenditure.

As dramatic as the cost and perinatal mortality and morbidity figures are in this two-year study at ORMC resulting from a fiscal policy which fails to provide the necessary funds for preventive care, it is reasonable to expect that these findings are representative of other obstetrical centers throughout Florida. Thus, the total yearly health bill throughout

Table 3. — Medical Complications of High Risk Clinic Patients.

	Number
Premature Labor	54
Chronic Hypertension	46
Diabetes Mellitus	66
CLASS A 22	
CLASS B 13	
CLASS C 23	
CLASS D 5	
CLASS R 3	
Pylonephritis	29
Renal Disease	13
Asthma	16
Epilepsy	19
Collagen Vascular Disease	9
Thyroid Disease	9
Cardiovascular Disease	9
Severe Anemia	8
Drug Abuser	16
Recurrent Fetal Wastage	23
Incompetent Cervix	15
Rh Immunization	5
Premature Rupture of Membranes	11
Hepatitis	4
Other	13

Table 4. — Effect of Prenatal Care on Pregnancy Outcome.

	PRENATAL CARE			
	None	Private	OCHD	HROC
Number of Patient No(%)	994(10)	6229(62)	2432(24)	365(4)
Cesarean Section				
Total No(%)	209(21)	1665(27)	425(17)	82(22)
Primary No(%)	111(11)	1201(19)	303(12)	55(15)
Low Birth Weight				
(LBW) < 2500 gms No(%)	339(34)*	503(8)	192(8)	49(13)
(VLBW) < 1500 gms No(%)	134(13.5)*	98(1.6)	29(1.2)	10(2.7)
Stillbirth Rate**	26.2*	8.4	11.9	13.7
Neonatal Mortality**	32.2*	3.53	2.88	8.21
Average Neonatal Cost for Surviving Infant	$5080*	$780	$660	$1090

*p<.001
**Per 1000 Live Births OCHD Orange County Health Dept., HROC High Risk Obstetric Clinic

the state must reach totally awesome proportions. It is, therefore, imperative to shift the emphasis from that of the acute care of the sick mother and neonate to the far less costly and more efficient programs of preventive medicine. This can be achieved through ensuring that all expectant mothers throughout the state are provided adequate prenatal care. Also emphasizing extensive sex and contraceptive education would help avoid the high percentage of uplanned and unwanted teenage pregnancies that contribute a high percent to premature birth and perinatal morbidity.

References

1. Pritchard, J.A., MacDonald, P.C., and Gant, N.F.: Williams Obstetrics, 17th ed.:4, 1985.
2. Wegman, M.E.: Annual Summary of Vital Statistics — 1983, Pediatrics 74:981, 1984.
3. Koops, B.L.; Morgan, L.J., and Betaglia, F.C.: Neonatal Mortality Risk in Relation to Birth Weight and Gestational Age, J. Pediatr. 101:969, 1982.
4. Morales, W.J. and Koerten, J: Obstetrical Management and Intraventricular Hemorrhage in 488 Very Low Birth Weight Infants. Submitted for publication. Obstet. Gynecol. 198
5. Creasy, R.K.; Gummer, B.A., and Liggin, G.C.: System for Predicting Spontaneous Preterm Birth, Obstet. Gynecol. 55:692, 1980.

- Dr. Morales, Orlando Regional Medical Center, 1414 South Kuhl Avenue, Orlando 32806-2093.

MED TECH '86



PLAN TO ATTEND THE #1 SYMPOSIUM ON THE #2 KILLER—CANCER!

JANUARY 20-22, 1986

CURTIS HIXON CONVENTION CENTER
TAMPA, FLORIDA

Qualifies for 18 Hours Category 1 CME Credit

UNIVERSITY of SOUTH FLORIDA — COLLEGE OF MEDICINE — 1956 STATE OF FLORIDA — CONTINUING MEDICAL EDUCATION

Featuring

THE 1st ANNUAL H. LEE MOFFITT INTERNATIONAL SYMPOSIUM ON CANCER BIOLOGY AND THERAPEUTICS

SEE AND HEAR INTERNATIONALLY PROMINENT SPEAKERS DISCUSS THE NEWEST DEVELOPMENTS IN CANCER RESEARCH, PREVENTION, DIAGNOSIS AND TREATMENT

MAJOR TOPICS INCLUDE:

- Biochemistry of the Cancer Cell in Selectivity of Drug Action
- Biological and Clinical Implications of the Tumor Cell
- Approaches to the Diagnosis and Treatment of Cancer
- Clinical Advances and Problems in the Treatment of Human Tumors
- Induction, Prevention and Modulation of Cancer
- Immunological Viral Aspects of Neoplasia

SPONSORED BY:

- University of South Florida—College of Medicine
- City of Tampa—
 International Trade Fair Advisory Board
- International Conference Management, Inc.

RESPOND TODAY!!!

CHECK ONE:

_____ Yes, I am interested in MEDTECH '86, please send Attendee Brochure to:

_____ Yes, our company is interested in exhibiting at MEDTECH '86 please send Exhibitor Prospectus to:

PLEASE PRINT:

NAME _____ TITLE _____

INSTITUTION or COMPANY _____

ADDRESS _____

STREET CITY STATE/ZIP

Mail to: **International Conference Management, Inc.** 15851 Dallas Parkway, Suite 1155, Dallas, TX 75248 214/458-7011

G

The pecuniary benefits of medical care

Every month the medical and lay literature reminds us of the enormous expense of health care. In 1984 the cost of medical care in the United States was 387.4 billion dollars, i.e., $1580 per person or about 10.6% of the gross national product. Physician services cost 75.4 billion dollars (19.5% of the total); dentists received an additional 25.1 billion dollars (6.5% of the total). The annual pronouncement of the health care expenditure figures automatically triggers a burst of editorial and political criticism. The medical community is being chastised for permitting the cost of health care to escalate. It is a moot point as to whether physicians, hospital administrators or medical academicians are in part or in whole responsible for the increase in cost, and I need not address this. I, however, do wish to explore the financial benefits of the increase in health care spending. Unfortunately the volume of studies examining the positive economic benefits of increased spending and health care is slender. A scan of the medical economics literature of the last three years reveals that studies on health care costs outnumber studies on financial benefits by a ratio of 98:1.

The benefits of health care to a patient and the patient's physician are usually perceived in terms of pain relief, disease cure or amelioration, alleviation of disability or prevention of more severe or fatal outcomes of illness. These outcomes are difficult to compute and, therefore, are of trivial concern to the health care fiduciary. Health economists, however, will acknowledge certain positive outcomes of health expenditure, e.g., reduction in mortality rates, savings engendered by prevention of conditions that will demand more intensive future expenditure of health care resources and prevention of wage loss.

The decline in mortality rates, particularly for white males, levelled off between 1950 and 1970. In the decade from 1940 to 1950, the mortality rate for the entire population dropped 22% but then fell less than 4% for some segments of the population per decade between 1950 and 1970. This stimulated Fuchs and a few other medical economists to express great misgivings about further expansion of health care investment. However, the introduction of Medicare and Medicaid and the increase in personal consumption of health care that began in the late 1960s and 1970s initiated a plunge in the slope of the mortality rate that has never been seen previously. The overall reduction in mortality dropped 20% in the 1970 and 1980 decades. The greatest reduction in mortality rate has occurred in the 45 to 54 and 65 to 74 year old age groups.

Mean mortality rates are listed in Table 1. As we expect, rates are lower for females than males and lower for whites than blacks. Ischemic heart disease and cerebrovascular disease account for 50 to 60 percent of all deaths.

Hadley published an extensive study on the relationship between medical care use and mortality.[1] His study population was large and national in geographic distribution, examined both urban and rural areas and included groups of all ages, sex and race. He discovered a significant correlation between the use of medical care and the decrease in mortality. His statistics revealed that a 10% increase in medical care expenditures per capita reduced future mortality rates for the whole population by 1.6%. For some groups, such as white males who are in their prime earning years between the ages of 45 and 64, the estimated decrease in mortality was even larger at about 3%. Translating these percentages in-

Table 1. — Mean Mortality Rates; Deaths/1000 Adult Cohorts

Age	White Male	Black Male	White Female	Black Female
45-64	13.86	22.82	6.57	13.88
65+	75.81	72.30	46.09	57.30

to dollar and human figures demonstrated that each additional $100,000 spent on medical care would prevent between 0.3 deaths in the 45 to 64 year old white female population, 1.9 deaths in the 45 to 65 year old white male population and between 3 and 3.9 deaths in the black male and female populations respectively.

A cynical economist might ask if this expenditure of an additional $100,000 is justifiable in monetary terms alone. What he is really asking is, "What is the dollar value on life?" This is a most difficult figure to assess, but Dolan et al. attempted to quantitate this.[2] Hadley reported that each additional $100,000 spent for medical care would save 1.9 lives in the 45 to 64 year old white male group. Dolan estimated that the value of life (expressed in 1977 dollars) for a male in the 40 to 45 year old age group was about $180,000, in the 50 to 54 year old age group $125,000, and in the 60 to 64 year old age group $45,000. Preserving 1.9 lives in the 40 to 65 year old age group, therefore, would justify the expenditure of an additional $100,000 in medical care. Furthermore, Dolan's estimates — if expressed in 1985 dollars — are quite low; an average 45 year old white male in this age group now earns over $20,000 per year and (even allowing for the discounting of the future value of money) he would be expected to earn about $500,000 during the remainder of his lifetime. Averting the death of a man with this type of earning potential is economically sound.

Surprisingly, similar estimates of the value of increasing medical expenditures apply to infant mortality rates. A 10% increase in health care spending in this age group results in about a 1.5% reduction in the mortality rate. For every increase of $100,000 in medical care, 1.3 black and 0.4 to 0.5 white infant deaths will be prevented. From 1960 to 1976, expenditures for infant health care increased and infant mortaliy fell 42% (from 26 to 15.1 deaths per 1000 live births). Thus, for both adults and infants, increased spending for health care results in fiscal payoffs which are measurable.

A second method for analyzing the pecuniary benefits of medical care is to examine the savings engendered by appropriate and timely utilization of the health care system. For instance, perinatal care for infants born to mothers who received no prenatal care, cost society 3 to 11 times more than infants born to mothers who received adequate prenatal care.

Long-term therapy for the management of hypertension has had salutary effects on the incidence of strokes, ischemic heart disease and other cardiovascular diseases and is responsible in part for the significant decrease in cerebrovascular accidents which has been observed over the past three decades.[3,4] The annual incidence of strokes per 100,000 population observed in Rochester, Minnesota decreased from 194 in the 1945 to 1954 decade to 103 in the period from 1975 to 1979. The largest drop occurred in the economically highly-productive 55 to 64 year old group in which the incidence fell from 370 to 170 per 100,000 population.

The cost of routine treatment of hypertension (excluding cardiovascular and cerebrovascular complications) is about 5 billion dollars annually. Is this cost effective? Definitely. The cost of caring for one stroke patient in the hospital is $13,000 to $19,000; post hospital institutionalization if necessary requires another $125,000 to $250,000 per patient for the remainder of that patient's lifetime. Assuming that an antihypertensive program prevents 100,000 strokes per year, that the average hospital costs of treating a stroke patient is $13,000 and that the antihypertensive program keeps 30,000 patients out of institutions at an average savings of $170,000 for the lifetime of the patient, then and effective antihypertensive program will conserve over 8 billion dollars per year in stroke prevention alone. Additionally, programs aimed at reducing hypertension have greatly reduced the deaths of cardiovascular and cerebrovascular diseases by 50%.

Typical savings in costs fostered by antihypertensive programs are obviously much greater than those mentioned here and far exceed the 5 billion dollar cost per year. Additional savings that accrue from preventing hospitalizations for heart failure and renal failure have not been incorporated into

these figures. Increased health care expenditures for the timely utilization of the health care system for the treatment of hypertension, therefore, has had a great payoff in lowering future consumption of health care resources.

Other examples of resource conservation can be enlisted. For instance, the use of psychotropic drugs for mental illness ablates the need for institutionalizing most of these patients and saves about $35,000 per year for the care of a single patient. Early aggressive therapy for the arthritic patient can prevent joint destruction in over 95% of patients, and savings derived from preventing the need for one joint replacement (which now costs about $8,000) can provide total care for an arthritic for 15 to 25 years. We, of course, could evoke many other examples from the specialties of diabetes, infectious disease and cardiovascular disease in which early medical intervention has been demonstrated to greatly diminish future demand for health care resources.

A third way to measure cost benefits is to examine the effect of medical care on job performance and wage production, but data pertaining to this are sparse. The cost to society of work lost from respiratory disease, arthritis, trauma and neurologic disease has been well documented. Studies are not available, however, that examine the effect of health care on worker productivity. The few small studies that have been published are limited to one or a few companies and indicate that a comprehensive health care plan, consisting of a physical fitness program, antismoking campaign and ready access to medical care, does increase worker efficiency and decrease absenteeism significantly.[5] Stamping a dollar value on such programs that apply to all workplaces throughout society is not possible.

We have been conscripted into a system of bottom-line medicine. Since physicians control about 70% of all health care expenditures, the insurance companies, politicians and corporations are attempting to handicap us with the burden of slenderizing the health delivery process. We should not permit the trimming functions to proceed too exuberantly. We must continually remind ourselves and others that medical care is not a financial sinkhole of indefinite dimension; rather, medicine can be a conduit to significant financial benefit for all of society. Perhaps national and state medical and specialty societies need to develop strategies to extend the measurement and reporting of the monetary benefits of health care.

Obviously not all health care provides a positive financial return. For instance, it is difficult to defend, by cost benefit principles, the care of the terminally ill patient or a great deal of elderly care, but the medical care system propagates enough monetary benefits to more than justify its humanitarian functions.

References

1. Hadley, J.: More Medical Care, Better Health? Washington, D.C.: Urban Institute Press, 1982.
2. Dolan, T.J.; Hodgson, T.A.; Wun, W.M.: Present Values of Expected Lifetime Earnings and Housekeeping Services. Hyattsville, Maryland: National Center for Health Statistics, 1980.
3. Matsumoto, N.; Whisnant, J.P.; Kurland, L.T., and Okazuki, H.: Natural History of Stroke in Rochester, Minnesota 1955-1966: An Extension of a Previous Study, 1945-1954, Stroke 4:20, 1973.
4. Garraway, W.M.; Whisnant, J.P., et al.: The Declining Incidence of Stroke. New Engl. J. Med. 300:449-452, 1979.
5. Jacobs, T.; Chovill, A.: Economic Evaluation of Corporate Medical Programs. J. Occupational Med 25:273-278, 1983.

Jacques R. Caldwell, M.D.
Daytona Beach

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

THE WORLD BOOK ENCYCLOPEDIA is now available through the FMA Magazine Program. Write or call for complete details of any current promotional offer.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

WE ARE REPRESENTATIVES FOR WORLD BOOK ENCYCLOPEDIA! Special: $100 off for educators until 12/3/85

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
American Artist(12)	19.00	19.00	10.97(9)
American Cage-Bird(12)	15.00	12.00	12.00
American Health(10)	14.95	12.95	11.95
American Heritage(6)	24.00	18.00	18.00
Amer.Photographer(12)	19.90	9.95	6.65(8)
2 yrs(24)		19.90	
Americana(6)	11.95	11.95	9.95
Analog:Sci-Fi(13)	19.50	19.50	9.97(10)
Antique Monthly(18)	18.00	18.00	13.00(12)
ArtNews(12)	29.95	25.95	25.95
Artist's Mag(12)	21.00	21.00	9.97(9)
Arts & Antiques(10)	36.00	29.95	29.95
Asimov Sci-Fi(13)	19.50	19.50	9.97(12)
Astronomy(12)	21.00	21.00	15.75(9)
Atlantic Monthly(12)	9.95	9.95	9.95
Attenzione(11)	21.00	21.00	7.97(8)
Audio(12)	17.94	17.94	8.97
Audubon Magazine(6)	16.00	16.00	15.00
Auto Racing Digest(6)	7.95	7.95	5.97
Backpacker(6)	18.00	14.97	14.97
Baseball Digest(12)	14.95	14.95	7.97(10)
Basketball Digest(8)	9.95	9.95	7.97
Beauty Digest(12)	15.00	15.00	15.00
Better Health/Liv.(6)	15.00	15.00	11.97
#Better Hms-Gdns(12)	12.97	6.49	
#Bicycling(10)	15.97	8.00	11.97
Bird Watchers Dig(6)	11.00	11.00	11.00
Black Enterprise(12)	15.00	9.00	7.50
Boating(12)	20.00	16.97	16.97
Bon Appetit(12)	15.00	15.00	15.00
Bowling Digest(6)	12.00	12.00	9.97
Boys Life(12)	13.20	13.20	11.97
Brides(6)	12.00	9.00	
2 yrs(12)		16.00	
Car & Driver(12)	17.00	11.99	11.99
Car Craft(12)	12.94	12.94	7.97
Cats (12)	17.50	17.50	12.50
Cat Fancy(12)	17.97	17.97	12.97
Changing Times(12)	15.00	9.97	9.97
Child Life:age 6-10(8)	11.95	11.95	9.97
Childrens Dig:7-11(8)	11.95	11.95	9.97
Childrens Playmate(8)	11.95	11.95	9.97
Circle Track(12)	19.95	11.95	11.95
Coinage(12)	14.00	14.00	11.95
Collectors Mart(6)	18.00	18.00	15.96
Columbia Journ.Rev(6)	16.00	16.00	9.95
Commentary(12)	33.00	33.00	33.00
Connoisseur(12)	19.95	10.00	19.95
Consumers Reports(12)	16.00	16.00	16.00
Cons.Rep.Travel Letter(12)		37.00	37.00
Crafts Magazine(12)	15.00	15.00	15.00
Cross Country Ski.(5)	11.97	9.97	8.97
Cruise Travel(6)	12.00	7.97	12.00
Cruising World(12)	18.00	18.00	14.00
Cycle(12)	14.00	14.00	6.99
Cycle World(12)	13.94	13.94	6.97
Daytime TV(12)	19.00	19.00	12.95
Digital Audio(12)	19.97	19.97	16.97
Discover(12)	24.00	13.00	14.95
2 yrs(24)		26.00	
Dog Fancy(12)	17.97	17.97	12.97
Dog World(12)	20.00	20.00	14.97
Downbeat(12)	15.75	15.75	7.95
Ebony(12)	16.00	14.00	9.97
The Economist(52)	85.00	51.00	51.00
Ellery Queen Myst(13)	22.75	19.50	9.97(10)
Esquire(12)	17.94	9.95	9.95
Essence(12)	12.00	12.00	9.00
Fact(12)	22.00	22.00	18.00
Family Circle(17)	14.97	14.97	
Family Computing(12)	19.97	11.97	11.97
Family Handyman(10)	9.95	9.95	5.95
Field & Stream(12)	13.94	7.94	7.94
2 yrs(24)		15.88	
Fifty Plus(12)	15.00	11.97	
2 yrs(24)		23.94	
Financial World(26)	41.95	24.94	18.95(18)
Fishing/Hunt.News(52)	29.95	29.95	21.95
Flying(2)	19.00	15.97	15.97
Food and Wine(12)	18.00	9.00	15.00
2 yrs(24)		18.00	
Football Digest(12)	12.95	12.95	7.97(10)
Forbes(28)	42.00	42.00	28.00
Fortune(26)	42.00	21.00	21.00
Forum(12)	18.00	18.00	15.00
Games Magazine(12)	15.97	15.97	15.97
2 yrs(24)		24.97	
Gentlemens Quart.(12)	18.00	13.50	
2 yrs(24)		27.00	
Glamour(12)	15.00	12.00	
2 yrs(24)		22.00	
Golf Digest(12)	19.94	9.97	9.97
Golf Illustrated(12)	12.00	12.00	6.00
Golf Magazine(12)	15.94	8.97	7.97
Good Housekeeping(12)	14.97	14.97	14.97
Gourmet(12)	18.00	13.50	15.00
2 yrs(24)		25.00	
Great Foods Mag.(6)	9.95	9.95	7.95
#Harpers Bazaar(12)	16.97	8.97	16.97
Harpers Magazine(12)	18.00	11.97	11.97
Health(12)	22.00	15.97	11.00
High Fidelity(12)	13.95	6.98	6.98
High Technology(12)	21.00	21.00	15.00
Hitchcock Mystery(13)	19.50	19.50	9.97(10)
Hockey Digest(8)	9.95	9.95	7.97
Home(12)	15.00	15.00	11.97
Home Mechanics (12)	11.94	6.94	6.94
2 yrs(24)		13.88	
The Homeowner(10)	18.00	13.97	7.50
Horizon(12)	21.00	21.00	16.00(10)
Horseman(12)	11.95	11.95	7.95
Hot Rod(12)	13.94	13.94	8.97
House and Garden(12)	24.00	18.00	
2 yrs(24)		36.00	
#House Beautiful(12)	15.97	7.99	15.97
Humpty Oumpty:4-7(8)	11.95	9.97	9.97
Hunting(12)	13.94	13.94	9.97
Inc(12)	24.00	12.00	12.00
Income Opportun.(12)	7.95	7.95	3.98(10)
Infoworld(51)	31.00	29.58	29.58
Inside Sports(12)	18.00	11.97	9.97
2 yrs(24)		23.94	
Instructor(9)	20.00	20.00	12.97
Jack & Jill:age 6-8(8)	11.95	9.97	9.97
Jerusalem Post(24)	18.46	18.46	15.97
Jet(52)	36.00	30.00	26.00
Jr. MD: age 9-13(4)	11.95	11.95	8.95
Ladies Home Jrnl(12)	20.00	17.97	10.00
Learning(9)	18.00	18.00	9.90
#Life(12)	27.00	13.50	22.50(10)
M:Civilized Man(12)	24.00	24.00	24.00
2 yrs(24)		42.00	
Mademoiselle(12)	15.00	12.00	
2 yrs(24)		22.00	
Medical Update(9)	12.00	12.00	9.95
Metropolitan Home(12)	15.00	7.50	7.50
Modern Photography(12)	13.98	7.98	6.99
Modern Screen(6)	14.70	14.70	11.70
#Money(12)	29.95	15.00	19.95
Mother Earth News(6)	18.00	18.00	14.97
Mother Jones(12)	18.00	12.00	12.00
Motor Trend(12)	13.94	7.97	7.97
#Motorboat.& Sail(12)	15.97	7.97	15.97
Motorcyclist(12)	11.94	6.97	6.97
MS Magazine(12)	16.00	10.97	10.97
2 yrs(24)		21.94	
Musician(12)	18.00	18.00	10.97
National Geograph(12)	16.50	16.50	16.50
Nat'l Geogr.World(12)	9.95	9.95	9.95
National Lampoon(12)	9.95	9.95	9.95
National Law Jnl.(52)	55.00	55.00	27.50
The Nation (52)	28.00	28.00	9.95(24)
Natural History(12)	20.00	15.95	15.95
Needle and Thread(6)	14.00	14.00	10.50
Needlcrft.for Today(6)	14.00	14.00	10.50
New England Journal of Medicine(52)			
Physicians:		55.00	
Residents and Interns:		35.00	
Students:		30.00	
New Age Journal(12)	18.00	18.00	15.00
New Republic (52)	48.00	48.00	28.00
#New Shelter(9)	10.97	5.50	9.97
2 yrs(10)		10.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95
New Yorker(52)	32.00	32.00	20.00
2 yrs(104)		52.00	40.00
Newsweek(52)	41.00	20.80	20.80
2 yrs(104)		41.60	
Nursing Life(6)	12.95	12.95	12.95
Old House Journal(12)	16.00	13.95	13.95
Omni(12)	24.00	15.96	15.96
1001 Home Ideas(12)	22.00	15.97	11.00
Opera News(17)	30.00	30.00	24.95
Organic Gardening(12)	12.97	9.97	9.97
Outdoor Life(12)	13.94	6.97	7.97
2 yrs(24)		13.94	
Outside(10)	16.00	12.00	8.97
Ovation(12)	16.00	8.00	8.00
PARENTS(12)	18.00	9.00	11.95
2 yrs(24)		18.00	
Penny Power:Age 9 up(6)		11.95	11.95
Penthouse(12)	36.00	30.00	30.00
People(52)	51.50	51.50	25.75
Personal Computing(12)	18.00	18.00	8.97(9)
Petersens Photog(12)	13.94	6.97	6.97
Playbill(12)	15.00	15.00	15.00
Playboy(12)	22.00	19.00	19.00
Playgirl(12)	20.00	20.00	17.50
Popular Bridge(6)	9.95	9.95	7.95
#Popular Mechanics(12)	13.97	7.00	13.97
Popular Photogr.(12)	11.97	5.99	5.99
Popular Science(12)	13.94	7.97	7.97
2 yrs(24)		15.94	
Present Tense(4)	14.00	8.77	8.77
#Prevention(12)	13.97	7.00	13.97
2 yrs(24)		13.97	
Pro Football Wkly(33)	39.00	39.00	17.00(15)
Psychology Today(12)	15.99	12.97	12.97
2 yrs(24)		25.94	
Radio Electronics(12)	15.97	11.97	11.97
Reader's Digest(12)	15.41	15.41	15.41
#Redbook(12)	11.97	6.97	11.97
Road and Track(12)	17.94	10.99	10.99
Rolling Stone(26)	19.95	19.95	17.95
The Runner(12)	16.97	12.97	8.65(8)
#Runner's World(12)	19.95	10.00	12.97
2 yrs(24)		19.95	
Sail(12)	21.75	21.75	21.75
2 yrs(24)		38.00	
Salt Water Sptsmn(12)	18.00	18.00	18.00
Saturday Eve.Post(9)	12.97	12.97	12.97
Saturday Review(6)	16.00	16.00	12.00
Savvy(12)	12.00	12.00	6.00
Science '85(11)	18.00	18.00	13.95
#Science Digest(12)	13.97	6.99	13.97
The Sciences(12)	12.00	12.00	12.00
Scientific Amer.(12)	24.00	24.00	24.00
Sea Magazine(12)	15.94	8.97	8.97
Self(12)	15.00	12.00	N.A.
Seventeen(12)	13.95	13.95	13.95
Shape(12)	20.00	20.00	8.97(6)
2 yrs(24)		35.00	
Ski(8)	11.94	6.97	6.97
Skiing(7)	9.98	4.99	4.99(7)
Skin Diver(12)	13.94	6.97	6.97
Soap Opera Digest(26)	39.00	39.00	29.75
Soccer Digest(6)	7.95	7.95	5.97
Sport(12)	17.50	9.97	7.97
Sporting News(26:6 mo)	22.50	12.88	12.88
#Sports Afield(12)	13.97	6.99	13.97
Sports Fitness(12)	26.50	26.50	26.50
#Sports Illustr.(52)	53.50	32.00	26.75(54)
The Star(52)	32.00	19.98	19.98
Stereo Review(12)	9.97	4.99	4.99
Stereophile(12)	20.00	14.97	14.97
Success Magazine(12)	17.94	17.94	8.97
Superfit(6)	14.97	11.97	9.97
Teen(12)	12.95	7.95	6.95
Teen Beat(12)	11.95	11.95	10.95
Tennis(12)	17.94	8.97	8.97
Theatre Crafts(10)	24.00	14.95	14.95
#Time(52)	58.25	29.25	28.00(50)
#Town & Country(12)	24.00	12.00	24.00
Tours & Resort:(6)	12.00	9.97	9.97
Travel & Leisure(12)	25.00	12.50	25.00
True Story(12)	14.95	8.97	8.97
Turtle: pre-school(8)	11.95	11.95	9.97
TV Guide(52)	31.20	31.20	26.00
Twilight Zone(6)	15.00	11.97	11.97
USA Today(260)	92.00	92.00	78.00
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50
2 yrs(104)		41.00	
U.S.News Washington Letter		39.00	39.00
Us Magazine(26)	23.95	17.95	14.95
Vanity Fair(12)	12.00	9.00	
Vegetarian Times(12)	19.95	14.95	14.95
Venture(12)	18.00	18.00	9.00(15)
Video(13)	15.00	15.00	7.50
Video Review(12)	12.00	6.97	6.97
Village Voice(52)	32.76	32.76	16.50
Vogue(12)	24.00	21.00	
W Magazine(26)	26.00	23.00	17.95
Wash.Post Nat.Wkly(26)	52.00	52.00	52.00
Weight Watchers(12)	13.97	11.97	11.97
W.Coast Rev of Bks(6)	12.00	8.94	8.94
Wind Surf Magazine(12)	19.00	17.95	17.95
Winning[Bicycle](12)	19.95	17.95	17.95
Woman's Day(17)	15.13	15.13	15.13
Women's Sports(12)	12.95	12.95	8.95
Workbasket(6)	6.00	6.00	5.00
Workbench(6)	6.00	6.00	5.00
Working Mother(12)	11.95	9.95	9.95
Working Woman(12)	18.00	12.00	15.00
World Press Review(12)	17.95	17.95	11.98
World Tennis(12)	15.94	15.94	7.97
Writer's Dig.(9 iss)	18.00	9.97	9.97
Yachting(12)	20.00	20.00	16.97
Yankee (Colonial)(12)	15.00	15.00	12.97
YM(12)	14.00	10.95	10.95
#Business Card needed for Office Price			

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.

Guarantee: Our prices are the lowest, our service the best.

New Orders: Publishers take from 6 to 12 weeks to start your subscription.

Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLMD985

Increase your level of reimbursement
with AHM's vital seminar:

"Insurance Coding: Procedural CPT-85 and Diagnostic ICD-9-CM"

A one-day professional workshop designed to increase the proficiency of your staff in collecting what's due you. The latest revisions on specific Florida regulations.

Here are just a few of the techniques your staff will learn:

1. Why correct coding increases your level of reimbursement — now and in the future. 2. How the insurance carriers use coding. 3. How to recognize and code each procedural component. 4. Understanding relationships of diagnoses and procedures. 5. Step-by-step through the ICD-9-CM — where to begin. 6. How to avoid the "no-pay" and "desperation" codes.

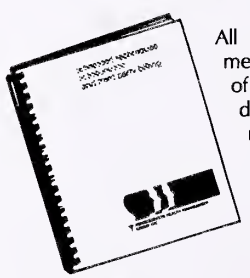
• How coding will input into fee profiles of the future. • Who codes the procedures and diagnoses that you don't! • How the insurance carriers use codes to lower your reimbursement. • Recognition of the diagnosis from the hospital chart or office record. • Use of simplified terminology to relate procedures as they appear "on your records" to the CPT-85. • Defining levels of service for higher reimbursement. • Your patient's chart — how to organize it for ease of coding and office efficiency. • Keys to unlock the complexity of the ICD-9-CM.

Any or all of the following staff members will benefit from our seminar: Insurance Secretary, Receptionist, Patient Interviewer, Credit & Collections Counselor, Bookkeeper, Assistants, New Staff Members, Office Manager, Supervisors, Coordinators, and Doctors.

Florida Seminar Schedule

Jacksonville	**Nov. 11, 1985**	**Jacksonville Airport Hilton • 14000 Dixie Clipper Dr.**
West Palm Beach	**Nov. 12, 1985**	**Hyatt Palm Beaches • 630 Clearwater Park Rd.**
Tampa	**Nov. 13, 1985**	**Marriott Hotel-Tampa Airport • Tampa Intn'l Airport**
Daytona Beach	**Nov. 14, 1985**	**Inn at Indigo Lakes • 2620 Volusia Ave.**
Orlando	**Nov. 15, 1985**	**Orlando Marriott • 8001 International Dr.**
Pensacola	**Dec. 10, 1985**	**Pensacola Hilton • 200 E. Gregory St.**
Clearwater	**Dec. 11, 1985**	**Sheraton Sand Key Resort • 1160 Gulf Blvd.**
Sarasota	**Dec. 12, 1985**	**Ramada Inn - Airport • 6545 N. Tamiami Trail**
Miami	**Dec. 13, 1985**	**Omni International Hotel • Biscayne Blvd. at 16th St.**

Seminars start at 9 a.m. and are over at 4:30 p.m. each date

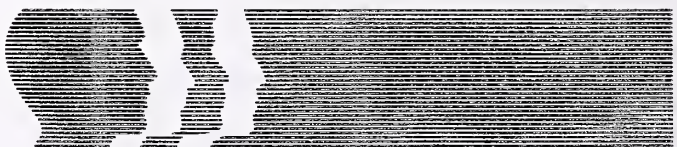


All seminars are taught by our highly qualified AHM staff members, backed by our company's 22 years experience of counseling in almost all facets of the health care industry. Tuition includes a comprehensive work-book/reference manual, sample forms and resource material plus refreshments. Seminar is tax deductible and is fully guaranteed or your tuition will be refunded if you are not completely satisfied. Over 38,700 physicians and their support staff have attended AHM seminars nationwide.

Fee: $135.00 each for one attendee from your practice.
$115.00 each for two or more attendees from your practice.

Attendance is limited...please register early!

Register: Call Toll Free 800-543-4332



ADMINISTRATIVE HEALTH MANAGEMENT GROUP, INC.
2600 Far Hills Avenue • Dayton, Ohio 45419

New Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

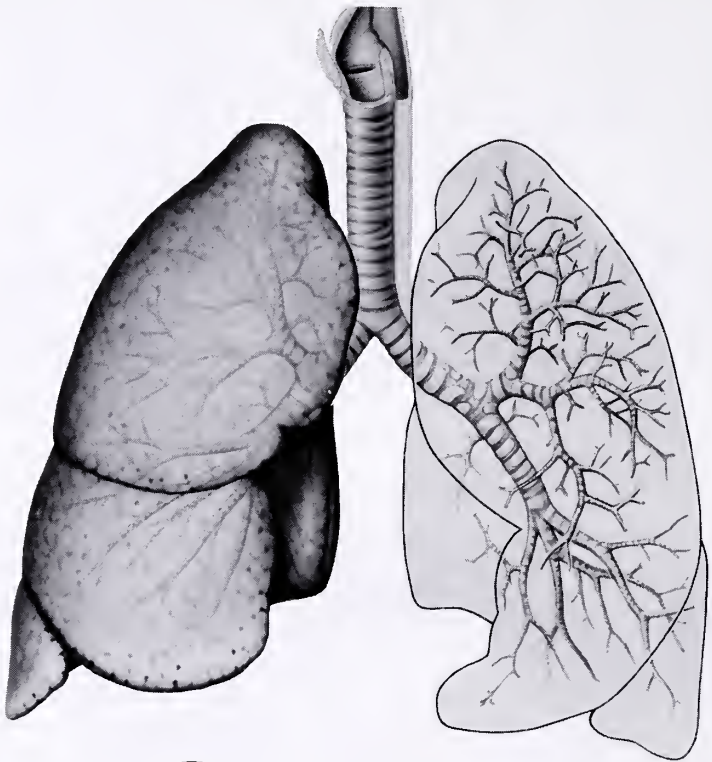
Upjohn

The Upjohn Company
Kalamazoo, Michigan 49001 USA

© 1985 The Upjohn Company

J-5491 June 1985

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

400441

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 863
- ☐ DEAN'S MESSAGE, 865
- ☐ ENCORES!, 865
- ☐ SCAM OF THE MONTH, 872

☐ NOTES & NEWS

1986 Leadership Conference to include House of Delegates Meeting

The 1986 Florida Medical Association Leadership Conference will be held January 24-26, at the Lincoln Hotel in Tampa. Due to change in the FMA Annual Meeting from May to September, an interim meeting of the House of Delegates will be scheduled as part of the Leadership Conference on Sunday, January 26.

The most ambitious and comprehensive program ever planned will begin with the Second Annual Leadership Skills Seminar for Women Physicians and an FMA Auxiliary meeting. Other programs scheduled Friday afternoon include a session for Hospital Medical Staffs, a meeting of county medical society executives, a workshop for Continuing Medical Education sponsors and a session on missing children co-sponsored by the FMA Auxiliary. An early bird reception will be held from 5:30 to 7:30 p.m. Friday evening.

Saturday morning offers a breakfast General Session featuring a presentation by FMA President Luis M. Perez, M.D., on present and future activities of the Association. Saturday morning will provide workshops on physician contracting, legislation and joint ventures. A General Session luncheon will follow with a prominent speaker to be announced. Saturday afternoon includes workshops on state government, unionization, risk management and media relations. To complete the day, a reception will be held beginning at 6:00 p.m.

Sunday morning hosts a FLAMPAC breakfast, and the House of Delegates will be convened at 9:30 a.m. by Guy T. Selander, M.D., Speaker of the House.

Detailed information about the 1986 Leadership Conference will be mailed in October.

JCAH's board approves revised "Rehabilitation Services" chapter of 1986 AMH

At its August 1985 meeting, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) adopted, revised and expanded "Rehabilitation Services" standards for inclusion in the 1986 *Accreditation Manual for Hospitals* (AMH). The standards reflect the increase in the scope and intensity of rehabilitation services provided by acute care, rehabilitation, and chronic disease hospitals. They were developed with the help of a task force of experts in rehabilitation care and were sent for field review to more than 4,700 individuals and organizations concerned with rehabilitation care.

The revised and expanded standards identify and provide quality of care guidelines for those ten rehabilitation services most commonly provided by hospitals. Those standards which are new cover prosthetic and/or orthotic services, psychological services, recreational therapy, social work services and rehabilitation medicine. Revised standards include occupational therapy, physical therapy, vocational rehabilitation, rehabilitation nursing services and speech pathology and/or audiology services. For each of these services, the standards specify relevant patient care activities and mechanisms to be used to monitor the quality of care provided.

The revised and expanded standards also provide specific requirements that programs must meet to qualify as offering "comprehensive" rehabilitation services. These requirements include providing a range of services that include medical and nursing care, physical and occupational therapy, social work, and speech and language services as well as any additional services needed by the patient population. In addition, the rehabilitation area of a hospital must have designated inpatient beds in one or more organized units with sufficient space, equipment, and qualified personnel.

The new "Rehabilitation Services" chapter will appear in the 1986 *AMH*, which will be published in October 1985. However, to allow facilities sufficient adaptation time, new elements of the standards will not become effective for accreditation decision purposes until July 1, 1986. Until then, the JCAH will provide recommendations pertaining to new elements in the standards. Contingencies will continue to be given, as usual, for those elements of the standards that remain unchanged.

Beginning July 1, 1986, a physician specializing in rehabilitation care will be added to the regular survey team in acute care hospitals which indicate

that they have a comprehensive rehabilitation program as one of their services. This is being done to provide additional survey and educational expertise relative to the rehabilitation standards. This individual will replace the regular physician team member when surveying freestanding rehabilitation hospitals.

USF researcher's discovery helps identify infant disease

Dr. Daniel Lim is one inventor who does not expect to become rich and famous even though his product bears his name.

He considers himself a scientist — one who would rather spend his time with his test tubes and students — deriving satisfaction that he's "helped mankind."

Lim, a microbiologist at the University of South Florida College of Natural Sciences, is the developer of a culture medium to grow bacteria. Named Lim Group B Strep Broth, his medium is designed to speed up the growth of bacteria, Group B streptococci (GBS), that infect 15 to 30 percent of all premature infants. Without treatment, 50 percent of diseased infants die within 48 hours. His strep broth makes it possible to positively identify high risk mothers and babies within five hours after testing.

The bacteria that cause the disease are common and carried in the vaginal tract by 20 to 30 percent of all women, said Lim. The vast majority of these women do not have the disease. The danger is when the woman becomes pregnant and "the bacterium is transferred to the infant."

One out of every 100 infants with the bacteria will develop a serious disease. The symptoms of GBS, immediately diagnosed at birth, include respiratory infection, sepsis or blood infection and meningitis.

Lim's wonder broth, an enriched test tube culture which is the result of six months of "looking at different enrichments, antibiotics and combinations" and putting them together as in a recipe, was developed three years ago. It has been on the market for one year.

But Lim's research really goes back seven years when he met with representatives of Pharmacia Diagnostics, a medical research firm. Aware of his ongoing work in studying streptococci, they approached him about researching products which, he said, turned out to be instrumental in developing the GBS broth.

Lim worked with the firm in developing a kit called the Phadebact Strep B Test to identify the bacteria. Another company, GIBCO Laboratories, is packaging his broth.

Pharmacia Diagnostics and GIBCO have provided Lim with $106,000 ($41,000 for research and $65,000 for chemicals, travel expenses and consulting fees) since 1978, but he does not receive any royalties, much to the surprise of his students.

"I feel the companies have been more than generous with me," Lim said. "They have supported my research here at USF. I see myself among those scientists who do not derive financial gain but derive satisfaction knowing that they have helped mankind."

Lim's testing procedure involves taking a vaginal culture from the mother just before birth and placing it in the test tube broth. Traces of the strep B bacteria will appear within five hours. Treatment with antibiotics, in most cases ampicillin, begins immediately after diagnosis.

"We can now treat infants and mothers who are high risk Group B Strep carriers and not worry about the others," said Lim. "No other technique can do this. We can avoid unnecessary treatment."

Infants, he pointed out, can have dangerous allergic reactions or other serious side effects from antibiotics. They also can build resistance to the drug so that it will be ineffective against later infection.

Lim does not take full credit for the testing procedure. He did the initial experimental lab work but when time came for a clinical evaluation of the medium, the borth went to Tampa General Hospital and, more currently, to Orlando.

A recently completed one-year study by Walter J. Morales, chief resident, obstetrics and gynecology, and Anthony F. Walsh, chief microbiologist, of the Orlando Regional Medical Center, has shown that high GBS-risk mothers treated with ampicillin six hours before birth deliver babies who are not infected by GBS.

In the test, Lim said, there were zero GBS cases in 710 mothers. In 1,274 untreated cases seven infants contracted the disease. Three died. In another 3,110 untreated patients seven GBS cases were reported with one death.

"We've made a dramatic breakthrough in eliminating death from this disease," he added.

Not content with the results, the team is researching methods to speed up the five-hour identification time, possibly developing a protocol where doctors can determine high risk mothers at bedside. They are also trying to discover more about immune systems and determine why some infants are more susceptible to GBS.

DEAN'S MESSAGE

Environmental adaptation

The evolution of the revolution is here. With the rapid growth in organizations offering alternative health care delivery systems, the future is very unclear. Insurance companies, investor-owned hospitals, non-profit hospitals, private industry, and even groups of physicians have entered the fray. At best, it is confusing to the provider and certainly must be for the consumer.

Of course, the impetus for this phenomenon is economical in nature. The retention of market share in a changing environment has become paramount. Competition and cost containment are here.

As defensive measures, some medical schools have entered the market offering health maintenance plans to their constituency.

One wonders where medical education fits into this matrix. How are students of medicine to receive a varied patient mix for their clinical education if the public is wedded to a closed alternative system? How does cost containment intertwine with education? While efficiency in patient care is an admirable goal, and cost containment can be achieved in every patient care system, will high-quality clinical instruction be permitted to continue?

A classic feature of a health maintenance organization is the front-end funding of patients with a 10% to 20% hold-back by the organization. If services provided are less than the hold-back, then there is a rebate to the physician. It is possible that personal financial gain will lead to errors in judgement regarding patient care. A two-tiered system of care will surely evolve. There may be flow charts devised and marketed for physicians to follow in order to depict the most profitable way to treat a given patient. Hence, education and the creative thought process — which have been a hallmark of our education — could be lost. A major shift in the setting of medical education would take place to a heavily outpatient-oriented setting. However, it is doubtful that the efficiency of a teaching setting will match the efficiency of a private office setting.

Therefore, the impact of the new health-care schemes on medical education must be scrutinized, and the best approach to address the problem will require the collective thoughts of all who have benefited from the high-quality medical education which we have received. Nevertheless, adaptation to the environment is a characteristic of *Homo sapiens*. With your assistance and counsel, adaptation will occur.

William B. Deal, M.D.
Dean and Associate Vice President
University of Florida
College of Medicine

ENCORES!

An important message for all licensed physicians

The Federation of State Medical Boards is a national organization composed of state boards of medical and osteopathic medical examiners from all states, federal territories, and Canadian Provinces. At its annual meeting, held this year in Atlanta, Georgia from August 25 through 27, one of the speakers in the Saturday morning session, August 27, on fraudulent medical credentials, was Kenneth Nelson, M.D., Medical Advisor, Office of the Inspector General, Department of Health and Human Services (HHS). Dr. Nelson presented data about the Inspector General's campaign to reduce Medicare and Medicaid fraud, and to collect health care monies collected under improper or illegal circumstances.

Florida was chosen as the pilot state, and Dr. Nelson reported that HHS anticipates recovering about $4.5 billion nationwide in funds that were improperly paid. One aspect of their efforts involves documentation of proper medical licensure by Florida physicians who receive federal health care reimbursements, and the HHS computer center in Atlanta is checking the accuracy of licensure data for all Florida physicians who now submit health care claims for Medicare and Medicaid beneficiaries. Numerous cases have already been identified and investigated of physicians who lack a current valid medical license but are submitting health insurance claims and receiving payment from the Florida intermediary, Blue Cross and Blue Shield of Jacksonville. Dr. Nelson stated that there are instances where Medicare intermediaries have not exercised enough care in reviewing the credentials of the physicians they pay federal monies to.

These investigations have already produced dramatic consequences for many Florida physicians whose only crime was the inadvertent failure to renew their state medical license as required by statute on a biennial basis. These physicians are considered to have practiced illegally during the period their license was inactive and they are ineligible to receive federal funds for services provided dur-

ing that time. Dr. Nelson related that the Inspector General will ask for a return of all money, and will also ask for interest and a penalty of $2000 per claim.

For a busy physician with a gross annual income of $150,000, with an estimated one third from Medicare, the result of the Inspector General's administrative action would be a payback of about $50,000 per year, plus interest and penalties of $2000 per claim. It is likely in a situation such as this, that a total reimbursement will be demanded of $100,000 or more per year in which the physician practiced with an inactive license. Failure to pay these monies would result in a forfeiture of future participation in Medicare and Medicaid, and possible other legal sanctions, such as having liens placed on personal properties and other assets. If the Inspector General suspected any fraudulent motives in the physician's practice or billing for federal money, criminal charges would also be added.

Aside from these federal difficulties, these physicians face administrative legal problems in Florida for having practiced with an inactive medical license, and for having failed to renew their license in a timely fashion as proscribed by law. The Inspector General's office has been working closely with the Florida Department of Professional Regulation (DPR), and the Board of Medical Examiners in this area.

All licensed physicians are obligated to keep the Board of Medical Examiners notified of their proper address, and they must make certain to keep their medical license valid. All renewal registrations are issued for two years and the present renewal will expire on December 31, 1985. All physicians should receive a computerized renewal application by November 1984, but if this fails to arrive, or if the physician fails to mail the registration form back to DPR with the proper amount of money, his/her medical license will automatically become inactive on January 1, 1986. If that physician practices in 1986 with an inactive medical license, that practice is done so illegally and in violation of state law. The physician will face an administrative complaint and penalties by the Board of Medical Examiners, including an administrative fine and a reprimand. In addition, any monies received from federal, and possibly even private insurance carriers during this period when the license was inactive, must be returned to the government with interest and penalties.

Several Florida physicians have already been disciplined by the Board of Medical Examiners for having failed to renew their license, and for having practiced with an inactive license. They were issued a reprimand and an administrative fine upon the reinstatement of their license, and they face grave financial and possibly even legal sanctions from the federal government. Several physicians, including one from South Florida, had practiced for as long as three years with an inactive license and he may be asked to reimburse the federal government for several hundred thousand dollars or more. In addition, they face the possible loss of participation in Medicare and the devastating effect that could have on their practices. It is uncertain now what sanctions, if any, will be applied by private insurance companies. States attorneys could also, if they wish, file criminal charges for practicing medicine without a medical license, which is a third degree misdemeanor.

All physicians must possess a current valid medical license. Doctors should keep the wallet registration certificate in their wallet or on their person in some other way, and they should check it periodically to verify the listed name, address, and expiration date. Failure to renew, even when done inadvertently in the absence of malice, can result in severe difficulties and should be avoided by the relatively easy process of renewing in a timely fashion and notifying the Board of Medical Examiners of any address change.

Endorsement licenses • An analogous situation has arisen when physicians, who receive a Florida medical license by endorsement, fail to notify the Board of Medical Examiners of their practice, as required by statute, during the first three years in which they possess that endorsement certificate. The holder of an endorsement license must prove one year's medical practice in Florida, commencing during the 36 months after the license was issued, in order to make that endorsement license permanent and unrestricted. If the holder of the endorsement license fails to do so, that license is declared null and void on the third anniversary date of its issuance, and practice after that time is done with a license that is null and of no legal authority.

Physicians who receive an endorsement license, must notify the Board of Medical Examiners of any change of address or status, and must make certain to document their one year practice in Florida, which must have commenced before the third anniversary date of the issuance of the endorsement certificate. Extensions of the three year period are made to physicians in the military or residents at approved hospital training programs.

If there are any questions about biennial renewal, inactive license status, or Florida endorsement certificates, please contact Mrs. Dorothy Faircloth, Executive Director, Board of Medical Examiners, 130 North Monroe Street, Tallahassee, 32301.

Richard J. Feinstein, M.D.
Miami

Reprinted with permission from *The Florida Board of Medical Examiners Newsletter.*

What kind of justice is this?
Save us from the lawyers

The young professional couple had frustration in their voices, vengeance in their hearts and a lawsuit lurking in the back of their minds the first time they called. They were a columnist's dream, living symbols of a problem.

They had been stood up by a moving company, literally left on the doorstep when the moving van did not show up on what was supposed to be their last day in Washington.

He was already en route to their new home, and she was left with the kids, the dog and a 48-hour disaster. After perfunctory apologies, the movers admitted they had deliberately overbooked and come up short of vans; "we'll try have a truck there tomorrow afternoon." Of course, the people who'd bought the house were planning to move in in the morning.

Weeks later, the moving company reluctantly, begrudgingly, with not a twinge of remorse, agreed to pay their weekend motel bill plus a couple hundred bucks of other out-of-pocket expenses.

"Is that all we get?" the couple asked the other day. What about the two-day nightmare, the screaming kids, the anxiety and emotional damage? Somebody ought to make them pay, the victims argued. Otherwise what's to stop them from doing this to other people?

Shouldn't businesses that do wrong by their customers have to pay?

That question goes far beyond innocent Yuppies who lost a weekend out of their lives because of an unscrupulous moving company. It affects the women who suffered miscarriages, infections and death due to the Dalkon Shield made by A. H. Robins Co. And the people who died after taking Oraflex, the arthritis drug once made by Eli Lilly and Co.

Each of these cases provides evidence that America has no idea what to do about rogue businesses. We have no effective system for compensating the victims of business misdeeds, no good way of punishing the wrongdoers.

Look at how government regulators handled the case of Oraflex, a drug the government says has been "possibly linked" to 49 deaths in this country. Lilly admitted it did not disclose that it knew four people had died and six others had become ill after taking Oraflex. It is a violation of federal law not to report adverse reactions to a new drug; Lilly pleaded guilty.

So what did our government do? It gave Lilly a limp-wristed slap and charged the company with 25 misdemeanors, each carrying a $1,000 fine. A $25,000 fine for covering up facts that might have prevented 49 deaths.

If the alleged victims of Oraflex are to get justice, it will have to come in the courts, where dozens of lawsuits are now pending.

What happens to the Oraflex cases will depend not on whether the company did right or wrong, but on how the plaintiffs' lawyers do in court. If they outpoint Lilly's lawyers and persuade a jury to award punitive or compensatory damages, the attorneys may win millions for their clients or their heirs. If they screw up or are overpowered by Lilly's legal staff, their clients may not get much.

If there ae a hundred different lawsuits and a hundred different courts, there will be a hundred different verdicts. Not all of them will be just, but all of them will be justice as we know it.

Similar injustices are already occurring in the thousands of lawsuits filed over the Dalkon Shield. Robins has been fighting every claim, insisting its IUD is no more dangerous than any other. Robins has been winning some cases, but losing most of them — losing so many that last month it filed for bankruptcy court protection in hopes of minimizing its losses.

Robins' decision to duck into bankruptcy court is, by any reasonable standard of business ethics, a dirty trick. Robins is not bankrupt, not even close to it, not even after paying — with the help of its insurance company — $378 million in Dalkon Shield damages and another $107 million in legal fees. What Robins is trying to do is cut its losses, put a ceiling on the cost of the 5,100 Dalkon Shield claims that are still pending and avoid having its remaining assets nibbled to death, one verdict at a time.

Filing for bankruptcy is a dirty trick, but who can blame them? There is no more justice for Robins in the trial-by-tort system than there is for the women who wre killed or maimed by the Dalkon Shield. Some of them have gotten millions, others not a dime. It depends on the whim of judge and jury, the denouement of duels between courtroom gladiators.

When the legal fees in any series of cases top $100 million, it's clear that lawyers are part of the problem. Without aggressive plaintiffs' counsel, there would be no compensation for the victims of corporate crimes. But the lawyers are largely responsible for the entire nation's befuddled view of how victims of wrongs should be compensated.

We have developed not only a legal system but also a national mindset that cannot distinguish between the trivial and the tragic when it comes to injury.

Our courts cannot provide justice to either party in tragedies like the Dalkon Shield, yet we continue to insist we are entitled to punitive compensation when the moving van does not show up on time. I'm sympathetic with those folks, but the implications of their demand for recompense are more outrageous than the wrong they suffered.

No less trivializing to our court system is the lawsuit filed in Virginia recently by a woman who, while pregnant, was accused of trying to shoplift a basketball from a sporting goods store. They took her in the back room and made her prove she was not hiding the ball under her maternity top. The incident undoubtedly was not funny to her, but is a few minutes of hassle any justification for the $500,000 claim for punitive damages she has filed?

Egged on by our legal advisers, we have come to believe that for every wrong, there is a right to compensation in the courts. But we have to begin acknowledging that lawyer-to-lawyer combat is not the only way to assess blame and determine damages. There has to be a better way.

Jerry Knight

Reprinted with permission from *The Washington Post National Weekly Edition*, September 9, 1985.

Fee splitting in the '80s?

Almost exactly 20 years ago I began practicing Pathology in Lexington, Kentucky. The first order of business was to get my license registered at the courthouse. I had had my Alabama license registered when I was a resident and I imagined that it would be the same. You take your license down there and pay a couple of bucks and the lady stamps some stamps and so forth and it is done. Not so in Fayette County, Kentucky. In addition to all of the above you had to sign "The Book."

The Book was a large leather bound tome about eight inches thick composed of blank pages upon which had signed all of my predecessors all the way back, I suppose, to Ephraim McDowell, assuming the county included Danville back in pioneer days. In signing The Book, however, I had sworn that I was neither an "advertising doctor nor itinerant surgeon."

It is inevitable that things would change from pioneer days or even from the 60's. I do not know if physicians still have to swear and sign but I do know that the FTC has said that an organization in the learned professions (like the AMA) cannot tell its members NOT to advertise. I am happy to see that physicians have not indulged in the TV excesses and poor taste that the attorneys have. As for itineracy, I would imagine that any surgeon who works at UCH, Town 'n Country, and Brandon travels more in a day than could have been dreamed of back in those days.

Another item of ethical concern involves fee splitting. In times past I feel that we knew what fee splitting was. The AMA Current Opinions of the Judicial Council for 1984 says, "Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment." It states further, "In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed."

This seems to be pretty clear and I feel that we all have an awareness of what is meant. Now comes the 80's with prepaid plans and a multitude of different arrangements with physicians. In some of the plans a physician (or clinic) is paid a total amount of money for each patient (capitation) from which the physician must provide all health care including the services of consultants. It is easy to see that this physician will have more of this total amount left (dare I say "profit") if he (1) has fortuitously healthy patients or (2) under utilizes consultants or (3) chooses consultants on the basis of negotiations for fee discounts.

The last two approaches could lead to compromise of patient care and the latter has the same net effect as fee splitting. The consultant gives part of his fee to the referring physician in return for the referral — that it is given before or after the fact does not lessen the effect. It could be said that it is done because of the risk-taking of the referring physician. It could be said that these arrangements are those of the plan and the physician is just going along with them. Remember that the plan managers and administrators are businessmen and that physicians are supposed to be professionals.

It is said that physicians must become better businessmen in their practices. I agree that we should be more efficient, more prudent, and better utilizers, but I do not agree that medicine is no longer a profession in which fee splitting in any form can be condoned.

Glenn S. Hooper, M.D.
Tampa

Reprinted with permission from the *Hillsborough County Medical Association Bulletin*, September 1985, Vol. 31, No. 4.

Health policy in 1985 and beyond

Editor's Note: This is the prepared text of William L. Roper, M.D.'s Jerome Cochran lecture, which was to have been given at the annual session of the Medical Association of the State of Alabama on April 19, 1985. Dr. Roper, an Alabama physician, was forced to cancel his appearance due to the death of his mother.

I am grateful to the Medical Association of the State of Alabama and especially to Dr. Hyman for the invitation to speak to the Annual Meeting.

The year 1985 is a challenging one for American medicine. Although it is almost a cliche, it bears repeating that we are in the middle of a fundamental revolution of the American health care system.

Someone else recently put it another way by saying "The revolution is on. It may not have reached your area yet, but if you haven't heard the shouting you are not listening."

I was asked to give the Federal government view of health policy and I welcome that opportunity. It is important to put all of this in context. In recent weeks much of the attention of Washington and the rest of the country has been focused on the Federal government budget for next year. The President's proposal for Fiscal Year 1986 calls for more than 50 billion dollars in savings from what would otherwise be spent. As is rightly the case, health programs are included in these spending reduction proposals. The fundamental policy decision about this budget is "freeze." In an almost across the board fashion, an effort is being made to hold the line on spending in Fiscal Year 86 at the level it is in Fiscal Year 85. Much more will happen on the budget later this year and I am certain that all of you will be interested in specific items such as the proposal to exclude the physician fee freeze under Medicare for another twelve months.

But there is life beyond the 1986 budget. Despite all of the discussions now and in the future about budget matters, we need to continue to focus on the kind of health care system we want to shape for the future. We in America have the finest health care system in the world today. More of our citizens receive better health care services than is the case anywhere else. But that system does have problems and we need to address those problems directly. However, it is important to point out, as the President continually does, that those problems need to be solved in a way that builds on the fundamental strengths of our health care system, not such radical change as to destroy those strengths.

During the past year I have served as Chairman of a White House Working Group on Health Policy and Economics. This group includes representatives of the White House, the Treasury, the Department of Defense, the Department of Health and Human Services, the Office of Management and Budget, the Council of Economic Advisors, the Office of Science and Technology Policy, and the Veterans Administration. We have undertaken a fundamental review of health policy issues and are making recommendations for the President's second term agenda in health matters This review of health policy issues has presented an opportunity to look carefully at basic issues in health policy in America. I would like to discuss three of those in my remarks.

The overarching issue in health care today continues to be the cost of health care. You are probably quite familiar with the numbers — but we are devoting about 10.5 percent of our gross national product, more than 1 billion dollars per day, to health care. It is hard to turn on a television or radio or read a newspaper or magazine without being confronted with the health care cost issue. Indeed it is hard to say the words "health care" without following them with "costs." The three words are used together so often these days.

In the middle of all this media attention on health care costs, today's message is changing. In the past, all discussions about health care costs focused on what a terrible problem it was and how it was apparently beyond any sort of solution. Today's new coverage, however, presents a different story, one that is much more encouraging. The recent stories talk about what is being done to control health care spending increases, what is being done by business and industry, by doctors and hospitals, by state, local and federal governments. The rate of increase in health costs has fallen dramatically, to being only slightly more than the general inflation rate.

The Reagan Administration's position has been and continues to be that the fundamental problem that has led to such rapid increases in spending in health care is that incentives in the system have been backwards. Incentives — to patients, to families, doctors and hospitals, to the payors for health care services — the incentives have all been in the direction of increasing spending and almost no incentives in the direction of restraining spending

There continue to be a number of myths that abound in the health care cost debate:

- One myth is that inflation is the problem. When we look carefully, it is not inflation and certainly not health-specific inflation that has led to such rapid increases in health care spending. Rather it is increases in the intensity and sophistication of the services that are provided. In other words we are doing more and doing it better. After all that is what has given us this world class health care system.

- Another myth is that evil providers, such as greedy doctors or rip-off hospitals, have created this problem. Obviously you know that this is not the truth. We all have wanted this top quality system; we are now coming to understand how expensive it is.

- Another myth is that if anything is changed in the health care system, quality will immediately suffer. Quality is extremely important, and you and we need to do everything within our power to insure that quality continues. However, quality should not be used as simply an argument to maintain the status quo. If the Japanese have taught us anything in their manufacturing experience, it is that quality and productivity go hand-in-hand. You can increase productivity, increase efficiency, and at the same time increase quality. Many of you are demonstrating this in your practices today.

- Another myth is that it would be easy to control health care spending if only we had the will to do so. We need to be truthful with the American people on this score. The health care industry is a major employer. If we were to cut large amounts of health care spending, institutions would close, people would lose their jobs. In addition, we need to be truthful and explain that a large amount of the spending in the health care system is for people who are near the last days of their life. Productivity gains are important, but there are ethical issues to face as well. We are having a debate as a nation on these sorts of questions, and I think we are headed toward some solutions. But we need to be clear that this Administration is quite opposed to government being the arbiter as to who can have what kind of health care services.

- A final myth is that consumers of health care services are powerless to influence the system. The picture is often painted of powerless patients who cower at the feet of soverign physicians. Perhaps that was the case some years ago, but it is certainly not the case now. Patients and families are demanding more information on which they can make decisions about their health care.

To borrow a phrase from Ben Wattenburg, the good news is that the bad news is not true. The bad news about run away health care spending is wrong, because health care professionals and others all across the country are working to make our health care system more cost efficient while focusing on quality.

The second fundamental health policy issue is a continuing debate over appropriate strategy for controlling health care costs. For ease of discussion, it is a debate between competition and regulation. This Administration is convinced that the better way to have increased cost efficiency in our health care system is through greater competition, not through increased government regulation. We feel that we have had entirely too much government intrusion in the health care system in the past.

Here again, I would point to a changing message from the news media on this issue. Only a few years ago news stories about competition in the health care industry said we cannot have competition in health care. They said that health care was different, that it was not possible to have true market forces in health care. Now, however, the debate in the news media is over whether we like the competition that we now have. As you well know there is greatly enhanced competition out there, but I would point you to the news coverage of the recent artificial heart transplants by Dr. DeVries in Louisville at Humana, as symptomatic of the news media's debate over whether competition is a "good" thing.

Whether we like it or not, and I like it, I am convinced we are going to have much more competition in health care. This comes about not because of what government has done or will do, but because of the driving engine for change in health care is the private sector, business and industry. We have come a long way in the last four years under President Reagan towards a much more competitive health care system. The prospective payment system is an important step in that evolution.

But we must be truthful, and say that the prospective payment system is not a truly competitive, market place solution to the health care cost problem. It is a nationally administered price system that has too much government involvement in Medicare operations.

I believe that his Administration should view the prospective payment system as an important step away from cost reimbursement, but that we need to move even further toward a truly competitive system. I believe that one of the things that should be considered is capitation. Under capitation, Medicare beneficiaries would be able to enroll in a variety of competitive health care plans, and government would make payments to those plans on their behalf. Rather than trying to further constrain the system by adding physician services or skilled nursing facilities to the prospective payment system, under capitation the incentives would be given to doctors an hospitals for them to make cost-effective decisions about the most appropriate way to treat patients over the long term.

Despite our having moved substantially along the road toward competition, there will be some ef-

fort toward greater government regulation of health care:

- Many members of Congress continue to push for government regulation. This comes about because they have a fundamentally different view of government's role in society than does this Administration.

- The long term solvency of the Medicare program, while improved, is a concern. If Medicare's financial condition should worsen, I believe we would see many people urging that the system be regulated in order to preserve Medicare.

- Under competition, the issue of indigent care is a much more prominent one. Competition is forcing prices down, with less possibility of cross-subsidization from one group of patients to another. A debate is underway on how society should deal with the indigent care issue. It is important that this issue be resolved so that the health care system can move toward more competition. Many people have urged that the federal government step in to solve the indigent care problem. But in the time of very high federal budget deficits, it is certainly not possible. Many states are looking to regulatory means of solving the indigent care problem. Just as we have opposed regulation at the federal level in health care we would urge states not to consider regulatory means of solving the problems at that level.

- Another push we are beginning to see toward regulation fo the health care system comes from providers. Many people in the airline industry are looking nostalgically back to the days when the Civil Aeronautics Board regulated their industry. Similarly, some doctors and some hospitals are feeling the stress of competition and are beginning to suggest that we should go back to more regulation rather than more competition in health care in order to preserve their status quo.

The third fundamental health policy issue that we confront is the future of the Medicare program. The President has repeatedly said that Medicare is at the bedrock of the nation's commitment to the elderly and disabled and that we need to strengthen and preserve it.

The prospective payment system for hospitals under Medicare is the most significant change since the inception of the program twenty years ago. The recent Trustees' report tells us that under intermediate assumptions of Hospital Insurance Trust Fund will be solvent until 1998. This gives us time to study and evaluate alternatives for ensuring that the program will be fiscally sound long into the future. As I have mentioned, one of the approaches that seems particularly fruitful is capitation. Capitation is not an idea that only a few of us idealogues are pushing. A recent policy statement of the Chamber of Commerce of the United States urged that Medicare go to a capitated arrangement, which they described as "a defined and portable federal contribution" on behalf of each beneficiary. A recent article in *Fortune* magazine said "Vouchers. . . are the best long-term prescription for the rise in health bills." Vouchers, of course, are another way of describing capitation.

But capitation is a long term solution to the Medicare solvency question. In the meantime, there are a number of short term Medicare issues and questions. It is important that these shorter term issues be discussed with a view toward where they are taking us with the Medicare program. The following are some of these questions:

- Capital. The Administration is required to submit a report to the Congress on how Medicare's payment for capital should be handled under the prospective payment system. The Administration would like to establish a capital payment program that insures prospectivity and cost reimbursement. We feel that this would give hospital management the discretion to make such decisions. Some of these will be wise and some of them will be unwise decisions.

- Medical Education. In Fiscal Year 1986 budget, we have proposed a freeze on the direct medical education payment and halving of the indirect medical education add-on for Medicare. This has stimulated a great deal of discussion about the training of future physicians and other health professionals, and rightly so. In the time of excess numbers of physicians, and high federal deficits, it is difficult to continue an open-ended federal subsidy for the training of persons for careers that are generally very well paying.

- Physician Payment. This summer, the Administration will report to the Congress on the advisability and feasibility of paying for inpatient physician services using a diagnosis related group methodology. I know that this issue has stimulated a great deal of discussion and concern among physicians. We are in general agreement that the usual, customary and reasonable methodology no longer makes good sense. There is not agreement on how we should go in the

future. I have heard from many physicians about their opposition to "physician-DRGs." As you can tell from my remarks, I am interested in moving us more toward capitation, and I feel physician DRGs would tend to take us away from that goal.

- Professional liability. An issue of great importance to the physician community is the growing cost of professional liability. Hardly a day goes by that I am not asked what the Federal government is going to do to solve the medical malpractice problem. The AMA has a task force that has been studying the professional liability question and I am anxious to discuss further with the physician community the proposal that they will put forward.

As I said in the beginning, we are in a time of fundamental change in the health care system. The issue is not whether there will be a revolution, but whether it will be a good or bad one. The challenge that I put before you as physicians is to do all in your power to ensure that it will be a good revolution. This will be difficult, because we as physicians are no longer in the driver's seat; control has shifted from physicians to the purchasers of health care services.

What you as physicians need to do in this crucial time is to teach your patients, your purchasers if you will, to buy right. If they buy right, they will focus on efficient providers of quality health care services. If they do not, they will focus on cheap, shoddy providers. The only real alternative to teaching purchasers to buy right is government regulation. For all the reasons I have outlined above, the Administration is opposed to that as an alternative. Beyond being simply opposed, we are convinced that government regulation will not work.

What you as providers of health care services should do is work to define what quality health care means. It is no longer sufficient to say "I know it when I see it." Together we should develop quantitative ways of measuring quality so that these techniques can be used to assist purchasers in buying better services.

Additionally I would encourage good physicians to do everything they can to take charge of the new provider and paymnent arrangements that are being put together. I say do that now, while you still have leverage. If you do not and the health care system revolution continues without you, the good physicians will be the last to know. However, fundamental change is underway and I think good physicians must be at the forefront of leading that change.

Finally, I would urge that you remain fundamentally committed to delivering good health care services to your patients. Despite all of this discussion of cost efficiency and economics, the basic principle is delivering quality health care services to help patients. Please do not ever forget that.

William L. Roper, M.D.

Reprinted with permission from *Alabama Medicine, The Journal of the Medical Association of the State of Alabama,* July 1985.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The girlfriend in the office scam"

Prescribers need to be alert to a frequently employed indirect professional patient scam. In such instances, a drug abuser/dealer will cultivate a social relationship with a member of the office staff (receptionist, secretary, nurse, assistant, etc.) in order to gain access to prescription pads, drugs, forged signatures or even telephone prescriptions. Such techniques are possible when office personnel are minimally supervised. In such arrangements, the professional patient has a built-in bonus. The office accomplice is frequently able to intercept calls from pharmacists attempting to verify questionable prescriptions.

Caution • Prescribers can minimize the possibility of unethical/dishonest staff behaviors by maintaining good office discipline, tightly controlling prescription pads, communicating directly with dispensers, and being sensitive to the demands of the "street market."

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where
Southeastern Medical Data Systems
comes in.

Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

Write or call us for additional information and we'll get back to you immediately.

After all, we wouldn't want to try your patience.



southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

BOOK REVIEWS

Book Review Editor — F. Norman Vickers, M.D.

Imaging Anatomy of the Head and Spine

By H. N. Schnitzlein, Ph.D. and F. Reed Murtagh, M.D., 334 pages. Urban & Schwarzenberg.

In the introduction the authors comented that they had desired "to present, between one set of covers, the anatomical information needed to interpret most neurologically oriented studies performed with the major imaging modalities of C.T. or MRI" and indeed this is the case. This atlas is extremely well illustrated. The quality of printing and reproduction is superb. The figures are well chosen from good original images of first class quality CT scans, cadaver specimens, and good MRI scans.

With the present use of CT and the newer modality of MRI, sectional anatomy has become increasingly important. The authors correlate well the cadaver anatomy of the head and spine in commonly used formats with the comparable anatomy of CT and MRI scans.

These images are arranged together for easy accessibility and easy comparison. In addition, radiographs are included demonstrating the planes of sections as well as a summarized description accompanying the photographs of the CT and MRI images. Basically *Imaging Anatomy of the Head and Spine* represents a photographic color atlas of gross and microscopic anatomy as well as MRI and CT anatomy in axial, coronal, and sagittal planes.

The book is easy to use and one of the best features is that photographs of the gross anatomy, CT and MRI are well correlated and presented together. The anatomical sketches are labeled well and the descriptive summaries are concise and frequently emphasize pertinent anatomical features or clinical relevant signs and symptoms.

I would recommend this atlas for all practicing radiologists, radiology residents, neurologists and neurosurgeons who are involved in daily scanning. This book should be part of the radiology department that utilizes computed tomography or magnetic resonance imaging.

Charles D. Williams, M.D.
Tallahassee

- Dr. Williams is in private practice in Radiology and is Chairman of Radiology at Tallahassee Memorial Regional Medical Center and Chairman-Elect of the medical staff.

The Palm Beach Long Life Diet

By E. Joan Barice, M.D., with Kathleen Jonah, 278 pages. Price $14.95. Simon and Schuster.

In a time when almost any nonsense about diet and nutrition finds a large following if it appears in print, *The Palm Beach Long Life Diet* offers some sensible advice and deserves a wide readership. The author, Dr. Joan Barice, is board certified in Internal Medicine and Preventive Medicine and is a former

Assistant Director of the Palm Beach County Health Department. Drawing on her experience and interest in nutrition, Dr. Barice imparts a wealth of information on weight loss, vitamins and minerals, disease prevention, and exercise while debunking many of the myths on which the usual fad diets are based. The information is presented in a very positive, upbeat manner, however, and avoids sounding too much like either a medical text-book or the rantings that we "establishment" doctors too often resort to when asked about health and food.

Included in the text are complete menus for chemically and metabolically balanced weight loss diets for a standard or "core" week, an "easy" week, and a week of gourmet meals. Having tried some of these menus, I can attest that they are not only tasty and satisfying but bring the desired results. In a week of the core diet, both my wife and I shed the expected two pounds and felt good in the process. By adhering to the rigid schedule, we also developed a feel for the basic techniques of cooking and eating a low salt, low fat, no added sugar diet. The use of spices and complex carbohydrate foods to increase flavor and satisfaction is especially pleasing to the palate.

The Palm Beach diet is aimed at those who are above the age of 50,though most of what it says is true for any age adult. It is recommended reading not only for patients who might ask their physician's advice about dieting, but also for those physicians who are beginning to show signs of "Dunlop's Syndrome" (i.e. done lopped out over their belts).

Henry L. Harrell Jr., M.D.
Ocala

- Dr. Harrell practices internal medicine and is an Associate Editor of *The Journal*, Ocala.



AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA...
SHE'S ABOUT TO GIVE UP ON ORAL CONTRACEPTION.

NORLESTRIN®

1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP

1/50

BECAUSE SOMETIMES A 50 IS PREFERABLE.

See next page for brief summary of prescribing information.

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows.

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives; however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives; however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected.
(a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; benign hepatomas; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma; breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature, intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin 21 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin 21 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin Fe 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin FE 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin 28 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

0901G131

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

© 1985 Warner-Lambert Company

PD-21-JA-2563-P-1(11-84)

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

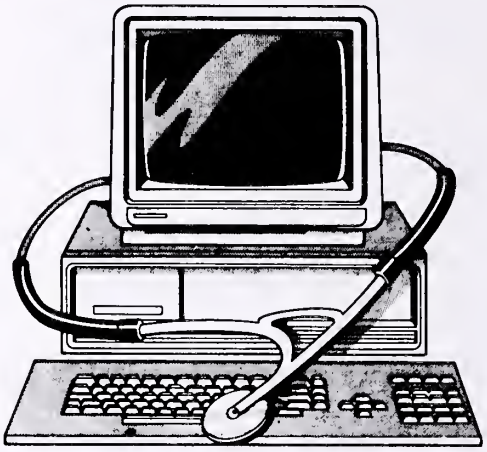
Please see full prescribing information on following page.

2/84

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

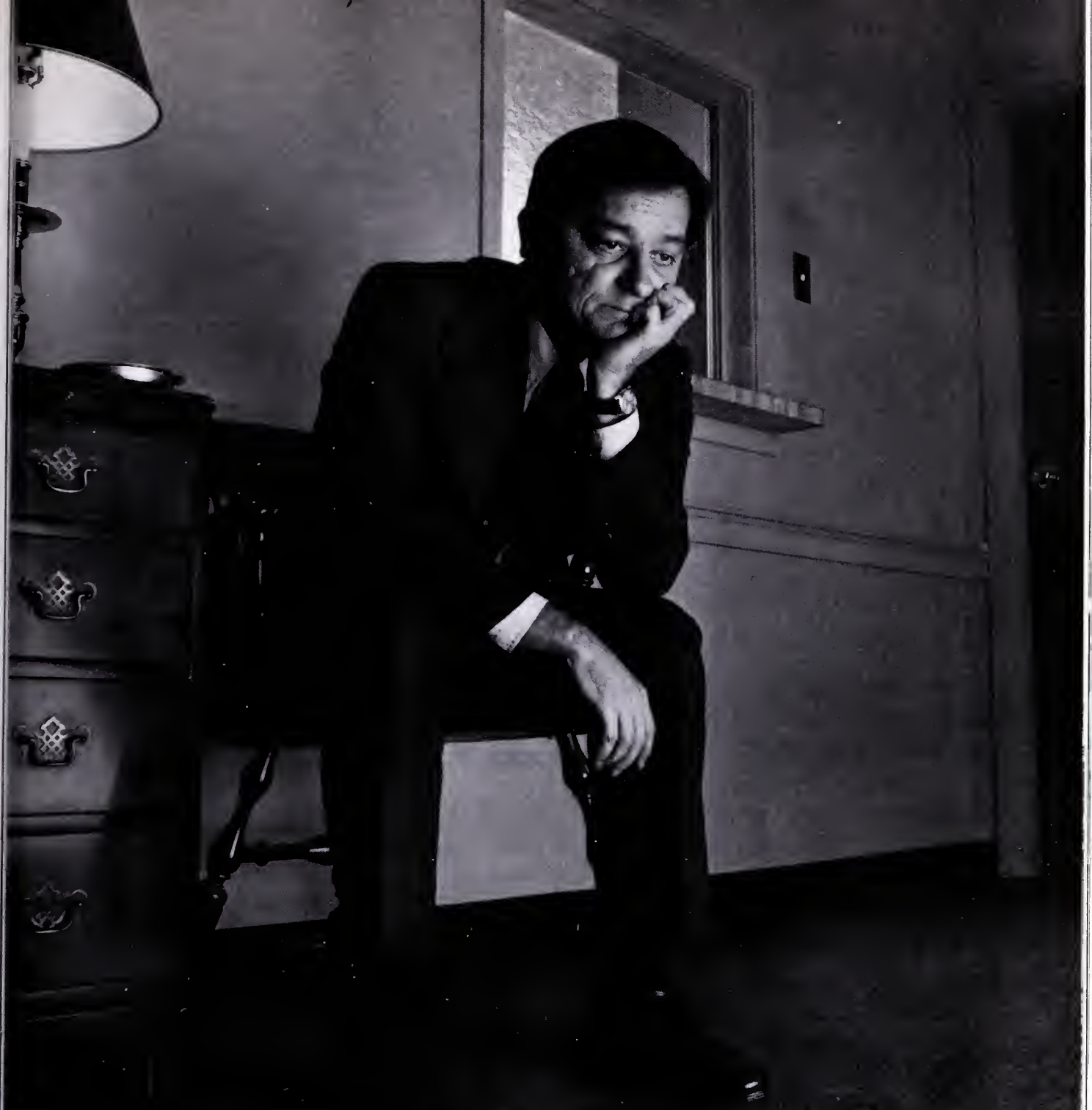
Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345



No One Is More Ill Than A Patient Who Tries To Hide His Illness From His Doctor.

You know it's not your everyday patient problem. Alcoholism is far different from most other diseases. Patients try to hide it from you. They resist treatment. They deny they have the disease at all.

Such a complex physical and emotional problem usually requires extensive evaluation. And intervention counseling is frequently needed.

If you are a specialist in addiction treatment, you're equipped to deal with these problems. If not, consider Brookwood Recovery Center as your specialist and partner in the treatment of alcoholism and drug abuse. We're a specialized facility staffed to serve both your patient and patient's family. Our nationally recognized treatment programs have given us one of the best recovery rates in the country. And once recovered, your patients and their families return to being the kind of patients that let you help them once again.

For further information on how a Brookwood Recovery Center can help you effectively treat this problem, call our treatment center in Orlando (305/841-7071) or Tampa (813/884-1904 or, toll-free in Pinellas County, 813/447-4806) anytime, day or night.

BROOKWOOD RECOVERY CENTERS

A health care service of American Medical International

Doctor:

What Are You Giving Your Practice This Christmas?

Buy the Medical Management System from Provider Automated Services BEFORE DECEMBER 15 and receive up to $1500 worth of free computer equipment.

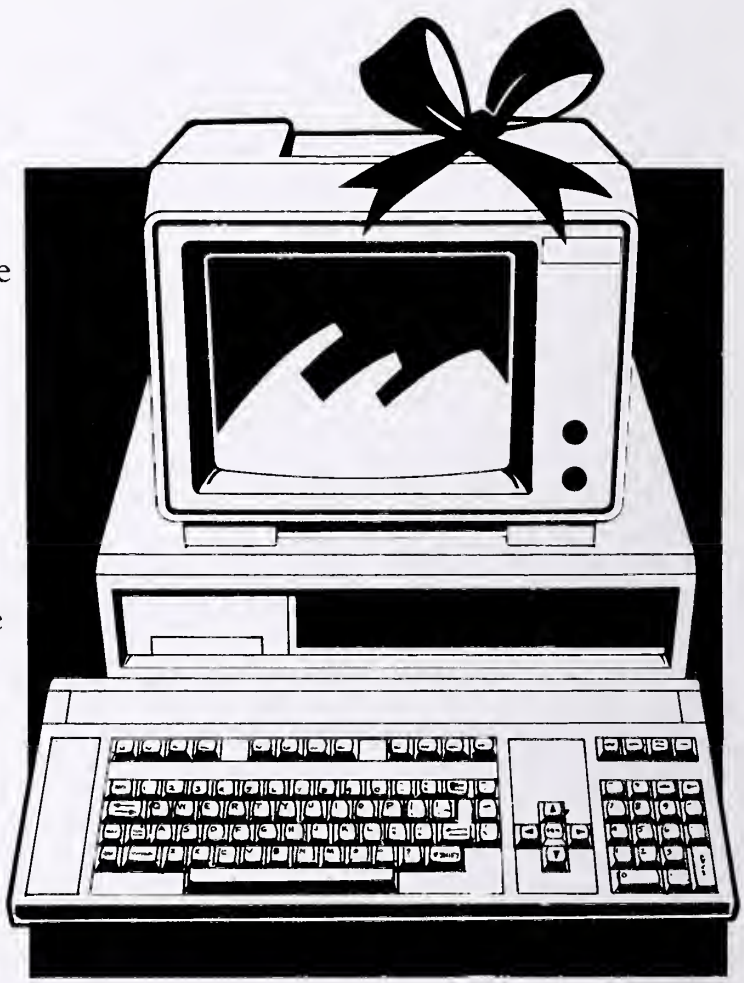
Let us automate your office during this special pre-holiday offer and you can choose one of the following presents for your practice:

- Correspondence-quality printer
- Data entry terminal
- High-speed modem
- Steelcase® computer furniture
- Business software package.

The Medical Management System will take care of your:

- Accounts receivable
- Patient billing
- Automated claims filing
- Other business functions.

This stand-alone system is specifically designed for a medical office... to give you better control of your practice.



Don't delay! Call your PAS representative (collect) at (904) 739-6730 before December 15!

PROVIDER AUTOMATED SERVICES, INC.

Subsidiary of Blue Cross and Blue Shield of Florida, Inc.

FLORIDA MEDICAL FOUNDATION
Needs Your HELP!

Please help by buying and encouraging others to buy:

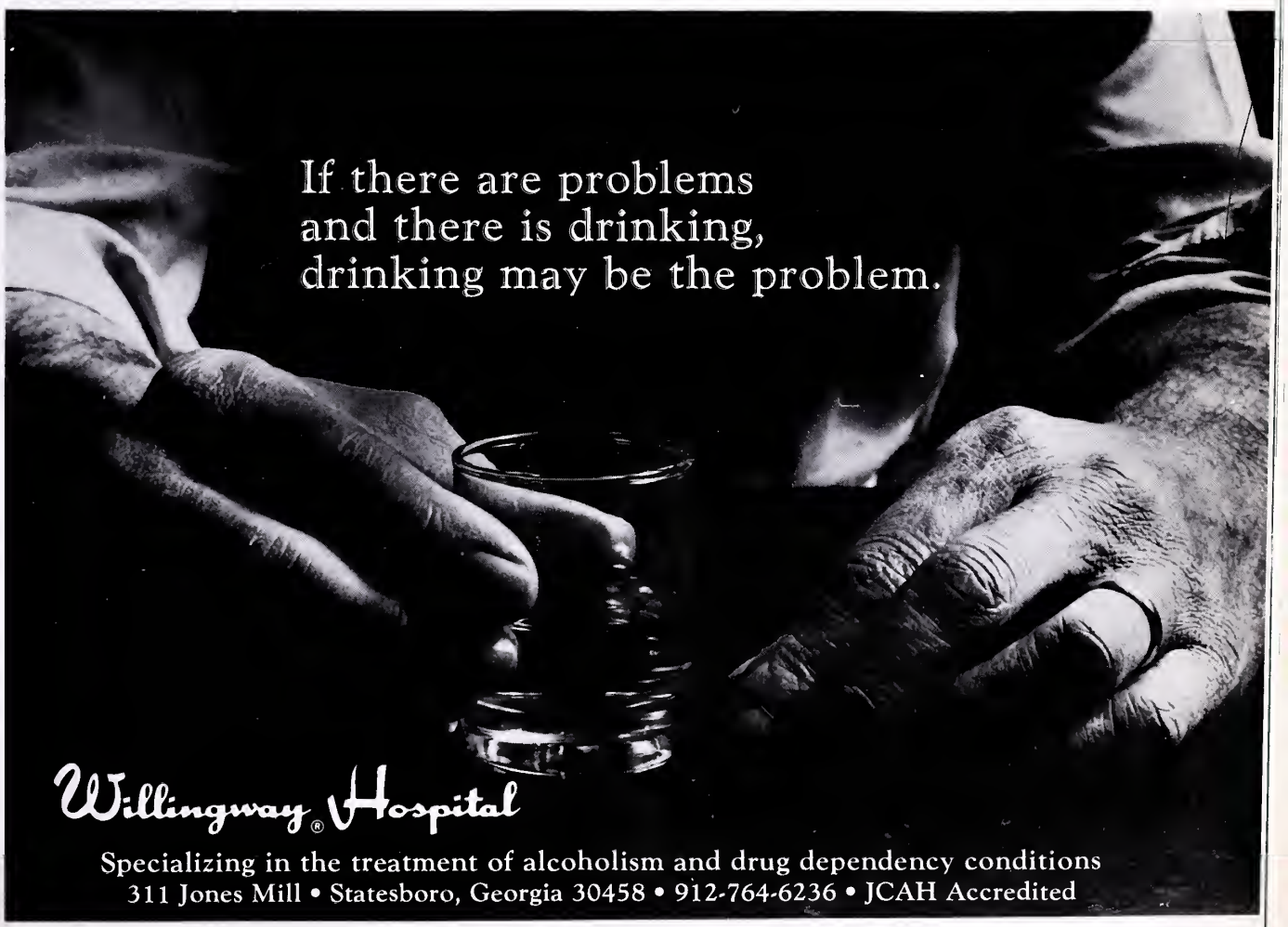
Healthy Florida Citrus
and
Fantastic Florida Pecans

The citrus is available throughout the year and can be mailed directly to your family and friends. The fall pecans will be a definite plus for your holiday baking or your gift list. Both are 25% tax deductible to the donor.

REMEMBER, of all the worthy Auxiliary projects, supporting FMF is the one thing we do for our "own." One of the most important uses of the profits is to support the Impaired Physicians Program.

Please continue to order citrus throughout the year. If you need brochures or order forms, contact your local auxiliary or:

Mrs. Gary M. Wright (Charlotte)
4171 S.E. 38th St. • Ocala, FL 32671
(904) 694-2248 or (904) 732-4032



Practices Available

INTERNAL-MED, FAMILY Practice est. 30 years for sale. Eager to retire. No reasonable offer refused. No cash needed for physician just completing residency. Five local hospitals require Board Eligible. Write Medical Center, P.O. Box 7603, West Palm Beach, FL 33405.

INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: DERMATOLOGIC PRACTICE. Fully-equipped and beautifully furnished offices in prestigious building. Ideally located in West Palm Beach, Fl. Could stay on one year or longer to assist in turnover. Great opportunity. Reply C-1287, P.O. Box 2411, Jacksonville, Fl. 32203.

THIRTY-YEAR FAMILY PRACTICE grossing $140,000.00. Four day week, 2,000 ft., equipped office lease-purchase on lake. Fish ocean, river, savannahs. Boat any direaction. Box 37, Jensen Beach, FL 33457.

N.E. COAST. Well established, fully equipped. Excellent community hospital (NICU & Pediatric Ward), charts, office, equipment, good will. Transferable. Easy terms. BE/BC. Contact C-1298, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

DECORATED OFFICE SPACE AVAILABLE in the beautiful Lighthouse Point Professional Building at 2211 NE 36 Street, Lighthouse Point, Florida. For details please call (305) 942-1444.

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

TALLAHASSEE: FOR RENT — Fully furnished office presently used as a dermatological practice. In beautiful medical park across street from new rehabilitation hospital and mid-way between two large hospitals. Call 904-877-3129 or 893-1385.

SHARE MEDICAL-SURGICAL OFFICE, 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441. Three exam rooms, lab, and business office. Patrick E. Callaghan, M.D., (305) 428-2420.

FOR RENT — Medical office suite in Vero Beach, FL; aproximately 3,000 square ft., excellent parking, attractive, sound brick building. Five year lease offered at $3,500 per month. Located on waterfront, 30 Royal Palm Blvd. — perfect for primary care physicians, family practice, or walk-in clinic. Call (305) 562-7922 and ask for Bruce MacIntyre. 701 Shore Dr., Vero Beach, FL 32963.

PRIME MEDICAL OFFICE Space for rent. Reasonable, near new hospital. ZephyrhIls, FL. For information, please call (813) 782-4505.

MUST SELL: Beautiful condominium Palm Beach Area. Two baths, 2 bedrooms, pool, private beach, sun deck. Contact: Karen V. Marks, P.O. Box 2914, Winter Park, FL 32790.

SHARE MEDICAL-SURGICAL office 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441. Three exam rooms, lab, and business office. Patrick E. Callaghan, M.D., (305) 428-2420.

BEECH MOUNTAIN, N.C.: Highest ski area east of the Rockies and largest in the state: For Sale: 2 br, 2 b, fully furnished condo with fireplace and balcony. Ice skating rink, hot tubs, sauna, steam room, heated pool, exercise room, tennis courts and shuffle board. On premise management: $88,900.00. Write C-1299, P.O. Box 2411, Jacksonville, FL 32203.

SUCCESSFULLY PROVEN Location. 682 sq. ' on Ocean Drive. (A1A) in Hallandale, Fl. High traffic count. Retired or semi-retired-condo area. Central Air-Newly carpeted. Scott 1-800-533-5564 (Fl.).

HIGHLAND BEACH, FL (near Boca Raton). East of Intracoastal. On island, deep canal dock, ocean access, walk to private beach. Low crime community. Four bedrooms/split. Built in 1982. Bette Conlon. (305) 391-9400.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

HOLTER SCANNING AND INTERPRETATION nationwide. For offices or hospitals at very special rates. Includes cardiology interpretation, immediate phone reporting, etc. Special rates for hospitals, HMO's. Will provide recorder and arrange for your office to learn patient connection, quality, etc. For information call Pittsburgh Cardiovascular, (412) 372-2035. 2550 Mosside Boulevard, Monroeville, PA 15146.

MEDICAL MARKETING section of the Florida Freelance Writers Assn. offers comprehensive services in writing, printing, advertising and publicity by professionals in all areas of Florida. For information and free estimates call (305) 274-0999 or write Larry Strum, FFWA, 11550 SW 82 Terrace, Miami 33173, member American Marketing and American Medical Writing Writers Assns.

WE BUY, SELL, LEASE SERVICE new and reconditioned medical instrumentation: EKG, Lab, Holter, scanners, 2 D. Echos, stress-test, etc. Contact: Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065, 305-972-4600.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

Equipment

COMPLETE RADIOGRAPHIC and Fluoroscopic X-ray room with 10 y.o. Picker 90/15 table. Mirror optics and precise optics T.V. system included. The image intensifer, fluoroscopic x-ray tube and automatic brightness system are only one year old. Call Kissimmee Memorial Hosp. (305) 846-4343, Ext. 387 for Dr. Sessions or Dr. Mayo.

FOR SALE: X-Ray equipment, Xonics Radiographic Room Control Table Tube Stand and AFP 14 XL Processor and other misc. equipment. Contact Dr. Steven Moss, 13910 Fivay Road, Hudson, FL 33567.

Meetings

WEEKLY SEMINARS. Most major ski areas, Club Med, Disney World, Cruising aboard sailboats in the Virgin Islands or a Mississippi Paddlewheeler. Topic: Medical-Legal Issues., Accredited. Current Concept Seminars, Inc. (since 1980). 3301 Johnson St., Hollywood, FL 33021, (800) 428-6069. $175.

EMERGENCY MEDICINE: Practice in beautiful Palm Beach County. Physicians needed for new group staffing two hospitals. Full or part time. Prefer BE or BC but will consider if experienced. Excellent compensation and malpractice insurance. Contact with CV: Medical Director, P.O. Box 273503, Boca Raton, Fl., 33427.

ADVANCED PEDIATRIC LIFE SUPPORT COURSE: The Florida Chapter of the American College of Emergency Physicians is sponsoring a seminar on "Advanced Pediatric Life Support." This seminar features a comprehensive review of basic and advanced pediatric resuscitation. Two separate approaches will be given: one for the physician and one for the nurse/paramedic. All those registered will be mailed an Advanced Pediatric Life Support text prior to the seminar. The Advanced Pediatric Life Support Course will be held November 14-16, 1985 at the Sheraton Twin Towers, Orlando, Florida. For further information contact REGISTRAR, 600 Courtland Street, Suite 420, Orlando, FL 32804 or call (305) 628-4800.

PRACTICAL DERMATOLOGY for the emergency and primary care physician: The Florida Chapter of the American College of Emergency Physicians is sponsoring a seminar on "Practical Dermatology for the Emergency and Primary Care Physician." This seminar features a ½ day format and will be held November 1-2, 1985 at the Hyatt Orlando, Kissimmee (Orlando), Florida. This program has been given ten (10) hours Category I CME credit by the American College of Emergency Physicians and the American Medical Association. The American Osteopathic Association has given (10) credit hours. For further information, please contact REGISTRAR, 600 Courtland Street, Suite 420, Orlando, Florida 32804, or call (305) 628-4800.

1986 CME CRUISE/CONFERENCES on selected medical topics: Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. Seven-twelve days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

American Diabetes Association

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.
CALL TODAY!

Florida Affiliate
(305) 894-6664

THE APPROPRIATE GIFT FOR AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Send the bill for $15.00 (add .75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Your Avis AWD Number:
A/A 616900

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

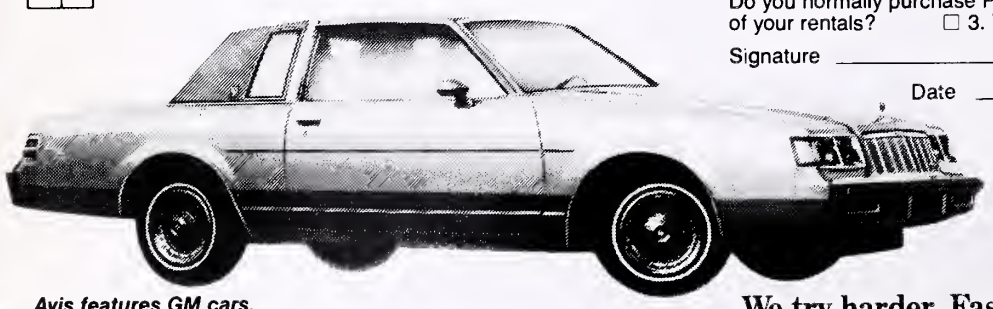
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ; LaGuardia Airport, NY; JFK Airport, NY and all Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

1985 Avis Rent A Car System, Inc., Avis®

3/85 Printed in U.S.A.

PHYSICIANS IN THE 90s

Visualize your practice

Investigate future-oriented issues

Vitalize your influence

AMA-Hospital Medical Staff Section
Sixth Assembly Meeting
December 5-9, 1985
Shoreham Hotel, Washington, D.C.

For information contact

American Medical Association
Hospital Medical Staff Services
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4747 or 4757

ADVERTISERS

Administrative Health Management Co.
Meeting 862

Air Force
Recruitment 846

Army Reserve
Recruitment 874

Ayerst Laboratories
Inderide LA 830a

BellSouth Mobility
Service 833

Brookwood Recovery Centers
Service 881

Brown Pharmaceutical
Android 824
Lipo-Nicin 883

Curtis 1000 Information Systems
Computers 880

Dorsey Pharmaceuticals
Hydergine LC 816

Eli Lilly & Company
Ceclor 862b

Florida Perinatal Association
Meeting 890

Florida Physicians' Insurance Reciprocal
Service 814

GTE Telenet
Service 820

Info Systems
Computers 890

International Conference Management Inc.
Meeting 856

Knoll Pharmaceutical Company
Isoptin 846b

Magnetic Resonance Imaging Center
Service 834

Marion Laboratories, Inc.
Cardizem 878a

Medical World News
Puplication 817

National Medical Enterprises
Recruitment 890

Parke-Davis
Norlestrin 877

Provider Automated Services, Inc.
Computers 884

Roche Products, Inc.
Dalmane 895

Smith Kline Beckman
Dyazide 846a

Southeastern Medical Data Systems
Service 873

Sports Medicine Journal
Publication 824

University of Alabama
Service 822

The Upjohn Company
Motrin 862a

Willingway Hospital
Service 885

Wyeth Laboratories
Ativan 829

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

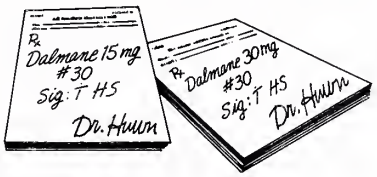
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓝ
sleep that satisfies

15-mg/30-mg capsules



References: 1. Kales J, *et al: Clin Pharmacal Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacal Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacal 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacal Ther 21*:355-361, Mar 1977.



DALMANE®
flurazepam HCl/Roche Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

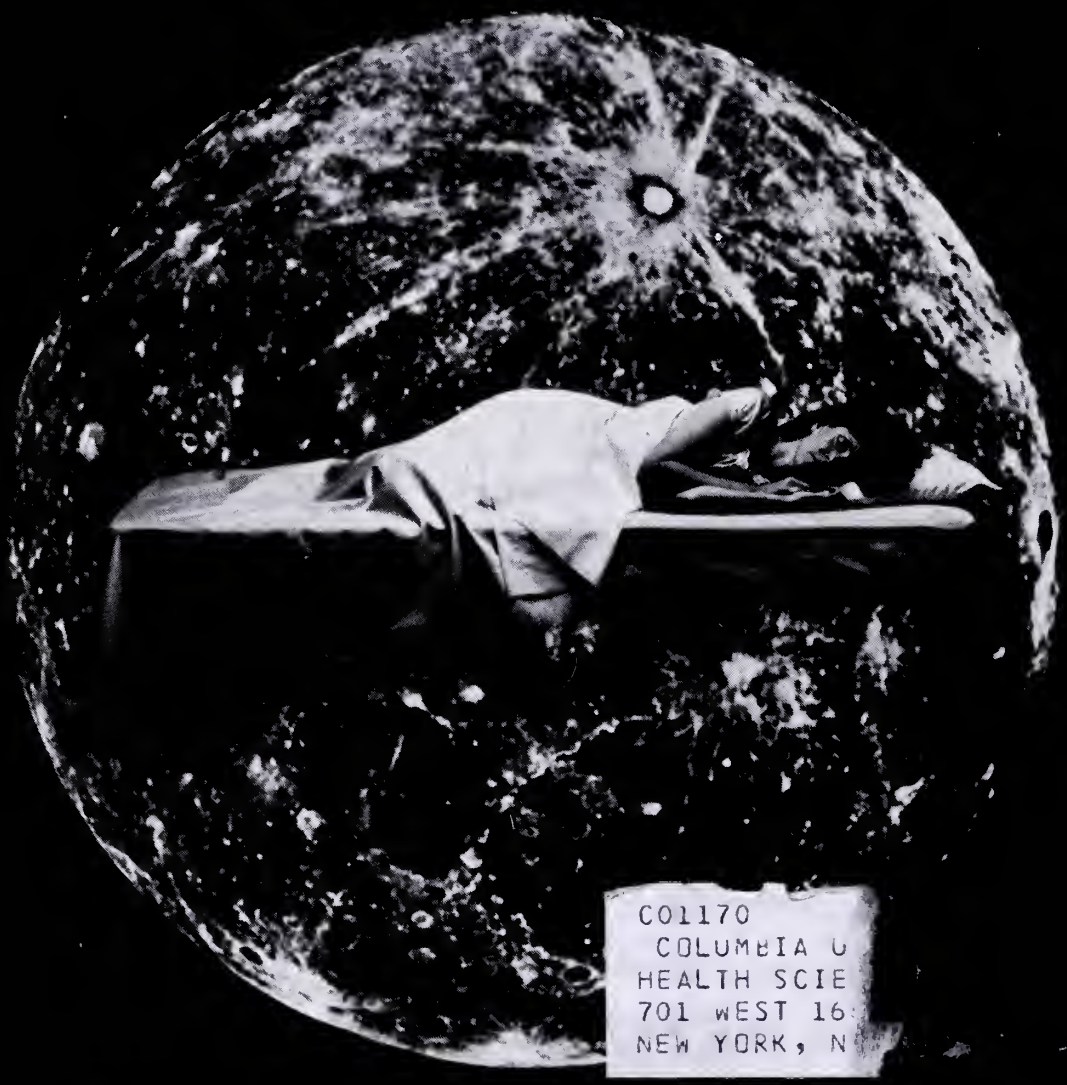
ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE®
flurazepam HCl/Roche ℞
sleep that satisfies



C01170
COLUMBIA U
HEALTH SCIE
701 WEST 16
NEW YORK, N

ROCHE

Copyright © 1985 by Roche Products Inc. All rights reserved.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. December 1985, Vol. 72, No. 12

COLUMBIA UNIVERSITY
DEC 3 1985
HEALTH SCIENCES
LIBRARY



SPECIALISTS

Your Florida Physicians Insurance Reciprocal specializes in professional liability insurance in the state of Florida.



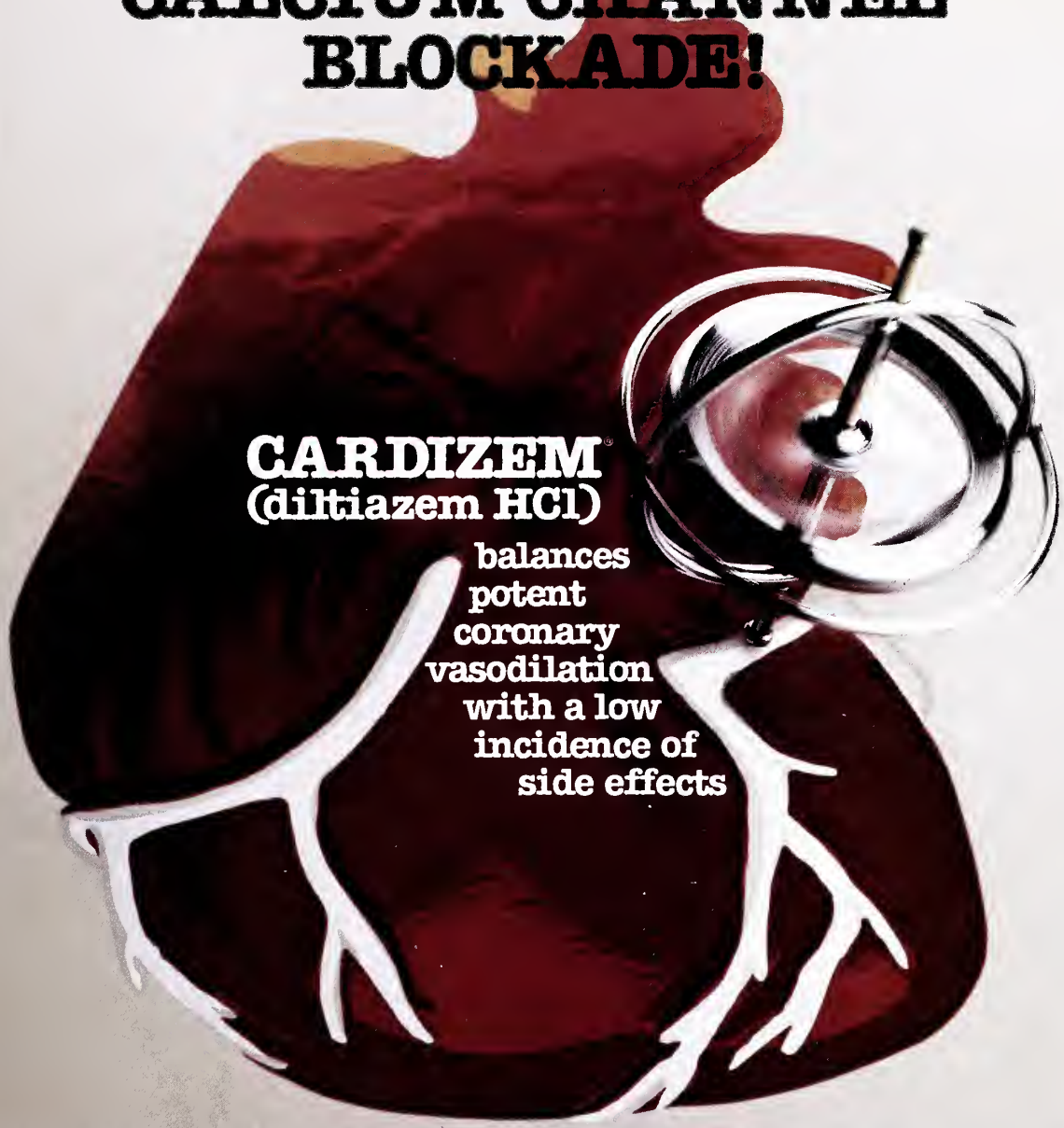
* The FPIR staff, management and underwriting and claims people are experts in their fields and are all located in Florida.
* The FPIR's consulting actuaries are among the nation's best and utilize only the best, most comprehensive data in rate setting.
* The FPIR has the top specialists for legal defense in both medicine and law.

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

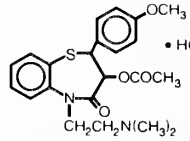
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where Southeastern Medical Data Systems comes in.

Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

Write or call us for additional information and we'll get back to you immediately.

After all, we wouldn't want to try your patience.

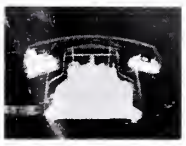


southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792



All of our medical know



MIST—Medical Information Service via Telephone.

It allows any practitioner in the United States to consult quickly with specialists at the University of Alabama Medical Center at UAB. So it helps physicians help their patients more effectively and quickly—without increasing the cost! MIST operates all day, every day.

By simply dialing a single toll-free number, a physician has immediate access to the latest research, clinical findings and protocols. It's a sophisticated communications link between phy cians and professionals in all areas of health car

MIST relies on the internationally recognized research and patient care centers at the Universi of Alabama Medical Center at UAB. Specialists i all fields are available to provide specific medica information and to discuss patient-related



ge is sitting on your desk.

oblems whenever they arise.
MIST isn't a new service.
Physicians and other health care professionals
ve relied on it as a fast source of medical infor-
ation and advice for over 17 years.
MIST is a valuable link for rapid access to medi-
information. So the next time you need help
th patient problems, referrals or emergency
formation, consult us.

Consult With A Specialist, Call

MIST: **1 800 292-6508** IN ALABAMA
1 800 452-9860 OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

December 1985, Vol. 72, No. 12

CONTENTS

SCIENTIFIC ARTICLES

Arlan L. Rosenbloom, M.D, John I. Malone, M.D., Anthony D. Morrison, M.D., and Jay S. Skyler, M.D. **1033** Screening for diabetes mellitus

Barry S. Tepperman, M.D., and Herbert E. Brizel, M.D. **1038** Endorectal irradiation — conservative therapy for cure of early rectal cancers

Bruce A. Rodan, M.D., William J. Bean, M.D., and David Mullin, M.D. **1042** Technetium 99m MDP uptake in drug-induced fibrous myopathy

COVER

This month's cover of *The Journal* is a drawing by Jacksonville artist James B. Upright. The cover illustrates the Holiday Season.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1985 by Florida Medical Association, Inc.

DEPARTMENTS

1019 President's Page
Reflections on the past bring goals for the future

1021 Editorials
The message of Christmas
Clyde M. Collins, M.D.
Cigarette smoking on trial
R.G. Lacsamana, M.D.
Corporate medicine and the American spirit
H. Frank Farmer, Ph.D., M.D.

1027 Letters & Viewpoints

1047 Medical Economics
The academic medical center as an endangered species
Jacques R. Caldwell, M.D.
Understanding the challenge facing teaching hospitals
James D. Bentley, Ph.D.
Richard M. Knapp, Ph.D.

1055 Notes & News

1056 Encores!

1061 Scam of the Month

1061 Correction

1063 Book Reviews

1067 FMA Auxiliary
The first male spouse in the Dade County Auxiliary
Melvin C. Greenfield, Ph.D.

1070 Meetings

1074 Classified Advertising

1077 Index to Volume 72

1082 Index to Advertisers

1082 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
Frank H. Farmer Jr., M.D., Ph.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Philip Altus, M.D.
Fuad S. Ashkar, M.D.
Thomas D. Bartley, M.D.
Pierre J. Bouis Jr., M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Mrs. Dale R. Charneco
Charles Craig, M.D.
R. Jay Cummings Jr., M.D.
Raul V. deVelasco, M.D.
Pablo Enriquez, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
James T. Howell, M.D.
Harold L. Ishler Jr., M.D.
Nicholas H. Kalvin, M.D.
Karl J. Kramer, M.D.
Jeffrey Lang, M.D.
Michael S. Levine, M.D.
Richard E. Lockey, M.D.
Mr. Dale Matza
Philander D. Morgan, M.D.
George Morris, M.D.
Richard S. Panush, M.D.
R.A. Penalver, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
Arvey I. Rogers, M.D.
William J. Romanos, M.D.
Hubert L. Rosomoff, M.D.
Lees M. Schadel, M.D.
Frederick W. Schert, M.D.
Jack J. Schneider, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Roberto A. Sosa, M.D.
Michael E. Steier, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victoria, M.D.
George Watkins, M.D.
Charles D. Williams, M.D.
Frederic C. Wurtzel, M.D.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

University of Miami School of Medicine — Department of Medicine
Twenty-First Annual Postgraduate Course

"Internal Medicine 1986"
March 2-7, 1986
Sheraton Bal Harbour Hotel — Bal Harbour, Florida

The objective of this course, the twenty-first in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medicine disorders as they are encountered by primary care physicians and practicing specialists.

Guest Faculty

Edward Mark Geltman, M.D., Associate Professor of Medicine, Washington University, School of Medicine, St. Louis, Missouri

Richard S. Panush, M.D., Professor of Medicine, University of Florida, College of Medicine, Gainesville, Florida

Oscar D. Ratnoff, M.D., Professor of Medicine, Case Western Reserve University, Cleveland, Ohio

Thomas Spira, M.D., Center for Disease Control, Atlanta, Georgia

Highlights

Symposium on "AIDS": An experienced faculty will discuss the latest developments of the Acquired Immunodeficiency Syndrome.

Meet the Faculty Sessions: Small group conferences in which topics dealing with critical care in internal medicine will be presented, followed by open discussions.

Pictorial Quiz: Our teaching method will cover all fields of internal medicine and will be available throughout the meeting.

Exhibits: Selected Scientific and Technical Exhibits will be on display.

Videotape Symposia: A large TV screen will show selected subjects at specific times.

Hotel Attractions: The Sheraton Bal Harbour is located in the exclusive Bal Harbour section of Miami Beach. The Sheraton Bal Harbour towers above a ten-acre tropical garden with 600 feet of private beach, an olympic-size salt water pool, and a fresh water indoor pool. A golf course and tennis courts are nearby. The Bal Harbour Shopping Center is right across the street.

Social Activities: A varied program will be offered daily for spouses and children.

Accreditation

This program has been reviewed and is acceptable for 33 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and for 33 hours by the American Academy of Family Physicians.

Registration: $500, $300/Physician in Training (Letter from Chief of Service must accompany registration)

For Registration and Information Write: Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

The ISI Software Question

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

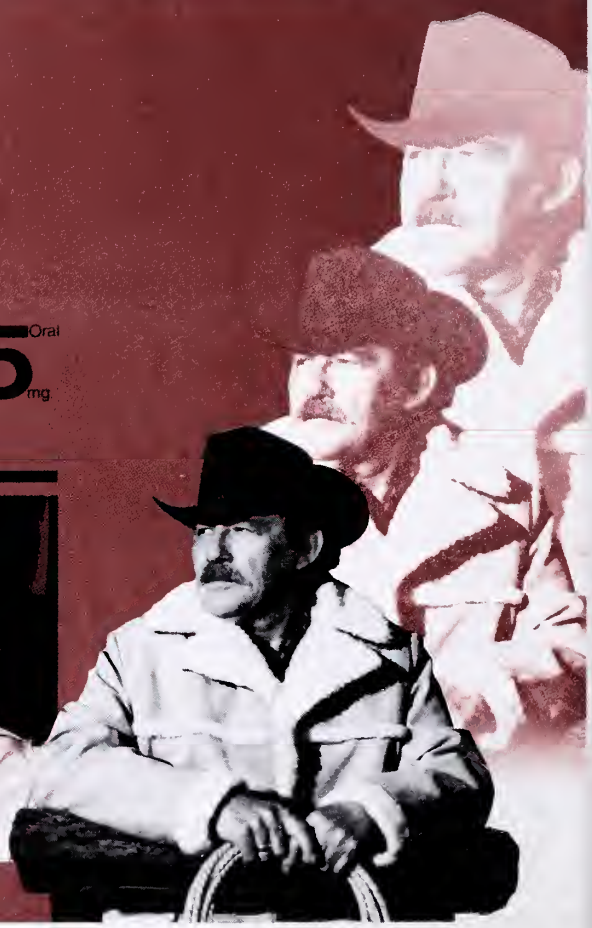
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg





Reflections on the past bring goals for the future



At this time of the year, when we celebrate the holidays with our family and friends in a gay and happy mood, all of us should take time to seriously reflect on this past year and make some well thought out plans for the up and coming year.

This year, for the first time in ten years, we saw a crack in the malpractice problem. We have to coordinate our movements and ideas to enlarge that small opening and obtain significant changes next April and May. That, we hope, will ameliorate the crisis in which we have been living with for so long.

We have to make some New Year resolutions and strive to keep these resolutions, such as becoming more interested in the political players of our state and learn how the game is played, so that we will be a more effective contributor in our struggle. We have to make a resolution to actively participate in our endeavors for the good of all physicians and for the benefit of our patients, the citizens of Florida, whose health and well-being are our responsibility.

We have to realize that the only harvest we can sow is from those seeds we have planted earlier, and the more we plant and care for, the better the harvest will be! This requires work and sacrifice from all who want to obtain bountiful results, because this is the only way to obtain results: sweat, toil and perseverance.

We have to use every opportunity, making opportunities if necessary, to talk with our representatives and senators now, when they are at home planning their next campaign. If they are of our liking, and willing to help us in our quest, we must help them in theirs. We must frequently remind them that the liability crisis is beyond the doctors/lawyer's position but a problem of society. They know it; the majority of them are business people or professionals other than lawyers, and even the lawyers are seeing their liability premiums escalate to high levels. We only have to make them aware of what is happening and that the people of the state indirectly are paying for it when these escalated premiums are passed on to them through increased prices for any service.

We have other serious problems approaching us, including the sunset of all the practice acts related to health, and we have to monitor the movements of allied health practitioners that encroach on our profession and obtain privileges for which they are not entitled by their degrees.

At the national level we have to face the attacks from the federal government to curtail medical services to the people. The HMO concepts and their variations open the door for entrepreneurs and corporations to try to control the physicians in this country while making a mockery of the best medical system in the world. All this is at the expense of the people without improving the services of the poor and destitute members of our society. We have to fight in Washington through the channels of the AMA and political work with our members of Congress, senators and representatives.

While reflecting, we must realize the strength that the medical community can have if everyone of us sacrifices some leisure time and works towards a

common goal. No organization can control physicians, unless the physicians themselves agree to be controlled and managed.

While thinking of the future, let us remember the past; we were able to practice medicine freely and efficiently without curtailment from any quorum or the pressures of malpractice. That is the medicine young doctors do not realize, those were the days when we really enjoyed practicing our profession. We owe to the young doctors of today, and the ones that will follow, such an environment. We have to find the formula to obtain that for the people of the state, preserving the quality of medical care and the opportunity like the past.

This coming year, let all of us resolve that we will pursue whatever sacrifice necessary to give a powerful push to our goals and make the whole nation realize that physicians of Florida, united in a common goal, can produce changes never before achieved.



The message of Christmas

"There's a beauty when it's Christmas
All the world is different then
There's no place for petty hatred
In the hearts and minds of men."

Christmas is our greatest holy day. Dedicated to children, laughter, love and sympathy, good impulses and the well-being of us all, Christmas is a tradition shared by all faiths. On this day in Bethelehem, with the birth of a child was born the concept of loving one's neighbor and of peace among nations. This was the child who grew to be the greatest believer in the human rights of man, a defender of women and children, one whose heart was always with the sorrowful, one who became great as measured not by the number of people in the world who feared him but by the number of people he freed from fear. Founding all progressive thought, He stressed the importance of compassion and integrity in a world full of neither.

Yet in the touching trust of childhood which can always be deceived, though never discouraged, lies the hope of the future of the world. To bolster this hope, we need only to follow the teachings of Him, the Prince of Peace whose message was that the mighty shall be toppled when their ways are wicked, for man's end is not power but peace and justice, and peace is impossible and justice a mockery unless power is put where it belongs in the hands of men who cherish wisdom and righteousness.

In spite of corroding cynicism, pessimism, greed, love of luxury and crass materialism, an individual's genuine needs are self-confidence, self-esteem, and self-sacrifice; and these can only be achieved by giving not getting, for to love people, to be indispensable somewhere, this is the purpose of life. By weaving a tiny personal thread of morality in our own lives, so can a nation weave a rope of exact and universal justice for all. The idea of morality goes to the bottom of men's relation with one another in terms of brotherliness, tolerance, help and mercy for there is always a universal hunger in the hearts of men for love, justice and truth.

The message of Christmas, "Peace on Earth" is a daily prayer in the hearts of enough Christians to drown the hue and cry of the hucksters, that the light of wisdom that blazed in the sky as a star shining on that first Christmas night, will someday enlighten the entire civilized world. Though this hope of peace on earth shining almost 2000 years ago still seems like a distal goal, yet each year at Christmas, hope is renewed to keep the faith that someday lasting peace and brotherhood will finally be achieved throughout the world. Christianity is an intensely practical religion not designed to change the way we think or believe as much as to change the way we act, yet what cannot be followed in day-to-day practice cannot be called religion. While many wrangle for religion, write for it, fight for or even die for it, Christmas teaches us to live for it.

Regardless of religious affiliation, we should resolve that on this day we will rededicate ourselves to those purposes which keep freedom alive, because without freedom there can be no justice and without justice there can be no peace on earth.

As it is impossible to have a good opinion of one's self and a low opinion of others, Christmas means you cannot love God without loving every fellow creature He made, and an act of contempt or rejection or neglect toward the least, the lowest, the poorest, or the weakest is an act against Him.

The meaning of the miracle behind the Christmas story is the simple miracle of understanding love, for the power to love was the Christ child's gift to all mankind and it can never be taken away from those who love. As it is in serving we are served, so it is in loving that we are loved.

And blessed are those who see Christmas through the eyes of a child. This is man's greatest gift at Christmas.

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

Cigarette smoking on trial

A strange but potentially landmark-setting courtroom drama pitting certain lung cancer victims against the powerful tobacco industry will be unfolding in the next several months. The lawyers representing the plaintiffs, who have all been chronic heavy smokers, are expected to contend that the cigarette manufacturers have withheld vital information concerning the dangers of cigarette smoking and have thus been remiss in failing to warn the public more adequately than current cigarette labeling does. Nonsense, the other side will argue; people who smoke know what they are doing, are aware of the hazards to their health of smoking, and should blame nobody but themselves if they get sick.

Very few people give the cancer-stricken patients any chance of winning the case; if they win, however, it would deal cigarette smoking a mortal blow that no previous effort by mankind had been able to deliver. It would indeed be a supreme irony to think that this may happen, but I hope it does not.

My sympathies lie with the cancer victims, some of whom may not live long enough to hear the verdict, but I am not swayed by their argument that they were victimized because they were not given enough warning about the hazards of smoking. I prefer to think they were victims of their own dangerous lifestyle, or addiction, or whatever you want to call it. The warning about smoking being hazardous to one's health is explicit and is found in every cigarette case; furthermore, it is common public knowledge that smoking causes a variety of illnesses, including cancer of the lungs, even though the cigarette companies are reluctant to admit this. But nobody is compelled to buy cigarettes and smoke them, much in the same manner that nobody is compelled to gorge one's self to obesity and die of premature atherosclerotic heart disease, or to sniff cocaine and blow up one's mind in the process. Much as a lot of us distrust tobacco companies, I happen to agree with them that the central issue in this case is individual responsibility. People who do certain things knowing that they may be risky should not be pointing fingers at other people if something goes wrong. To permit that would be to destroy the fabric of our society and to replace order with mayhem.

But what if the court decides that the cigarette manufacturers are indeed culpable of neglecting to give adequate warning to the public about the hazards of smoking? I can just imagine the resulting fall-out. McDonald's, Wendy's and Burger King will most likely be asked to warn their customers that eating their hamburgers will result in obesity, high cholesterol, heart disease, and strokes. The National Rifle Association probably will be ordered to modify its slogan to say that people do not kill people; guns do. Liquor manufacturers will be required to state on their labels that alcohol may cause cirrhosis of the liver, malnutrition, intoxication, or some other form of anti-social behavior. The possibilities are endless, but then the fun of living and doing a few dangerous things will be gone. The stability of our society would appear to be better served if the court finds that the suit against the cigarette companies is frivolous, which in some respects it is.

A better way to fight the cigarette manufacturers without abdicating our personal responsibilities or vicariously transferring these responsibilities to others when we should not is by confronting them with the mounting mass of evidence that we have against smoking, educating the public, and persuading the government to regulate the manufacture of tobacco and perhaps ban it altogether. Judging, however, from our previous record of failing to prohibit the use of alcohol, any similar attempt to ban the use of tobacco probably will be impossible. My hunch is that despite the scientific evidence, the government will continue to permit the use of tobacco with little or no modification of the warning that the Surgeon General now requires tobacco companies to place on their packages. Those who want to smoke and enjoy it should do so; if they stay healthy, more power to them. If they get sick, that is their tough luck. But please, let us not pass the buck to somebody else.

Whether the suit produces a landmark decision or not, it has stirred an unusual amount of interest from all sectors of society. The financial repercussions boggle the mind if some wise judge or jury finds that the tobacco companies are guilty and should compensate the current plaintiffs and all past and future victims of cigarette smoking. Such is not likely to happen. Physicians who have been crusading against the evils of smoking will be happy with a decision that will require more strict labeling on cigarettes. That would be at best a Pyrrhic victory. Do we honestly think that people will quit smoking by changing the labels on cigarettes? I doubt it, but I hope I am wrong.

R.G. Lacsamana, M.D.
Editor

Corporate medicine and the American spirit

As a former social historian, I have often looked at the elusive American spirit or character, that multifaceted entity which has been difficult to define, but which exists nonetheless. Throughout the history of this nation, all observers of American society have agreed that there are definite qualities which combine to make Americans unique. These qualities have been molded by the American experience, from the discovery of America to the migration westward and the development of an industrial world power.

Perhaps the foundation of our uniqueness is centered in our forefathers who represented the pioneer spirit and underwent great hardships and yet persevered and endured with a spirit that only can be described as irrepressible. America is a nation of immigrants, and whether these immigrants came from Ireland to escape the potato famine of the 1840's or from Europe to escape the oppression of Nazism during the 1930's, all of them were amalgamated into "Americans" and helped to give us the American character. This character was honed by hardships, such as the Civil War, the great Depression of the 1930's and two World Wars. It was strengthened by hardships on the Oregon Trail during the 1840's and droughts in Kansas in the 1880's.

The result of the building of this American character was apparent in the early days of our nation when our qualities set us apart as early as 1770 and helped lead to the American Revolution as England never really understood what made up the American character. This misunderstanding was partly responsible for our fight for independence. By the late 1800's the typical American was vastly different from his European cousin. While the ideas o socialism swept Europe, Americans had no time tc toy with this idea. We were too busy expanding westward, building our industrial plants and establishing our own identity. Besides, we were imbued with the spirit of capitalism.

What is the American character? It is many things. Above all, it is individualism, pragmatism and a toughness which may be disguised, but is always present. As a nation, we are the best fed, best housed and with the exception of the Civil War, have never had a major war on our soil. Because of our standards of living many nations have underestimated the American character as being one of softness — and have paid for that mistake as did the Japanese warlords in World War II. The American toughness and ability to suffer great hardships is illustrated in the Civil War when Americans fought some of the most sanguinous battles in history and troops from both sides, Americans all, continued to answer the bugle call for more charges and self-sacrifice.

With this toughness, and perhaps out of the pragmatic nature of the Americans, would come the desire for experimentation and innovative thinking. This would apply to all phases of society and particularly to the economic sphere when we built up the capitalistic system to the most efficient in the world. It has become as American as apple pie to do things the capitalistic way. Let the market place decide. The hard worker and the intelligent investor will be the winner. The thinking behind this is that the public will choose the best product, at the best price and economic competition is the backbone of our society. Indeed it is and it should be.

Today, the rise of corporate medicine has generally been received with either scorn, fear, or great expectations that this movement is the ultimate of the capitalistic system. Regardless of one's own personal feelings, there is little doubt that corporate medicine has become the newest player in the game and may be the principal player in the next decade. Those who expect corporate medicine to dominate the medical scene and private practice, more specifically fee for service, to decline to negligible levels have based their observations on several things. For one, they point to various aspects of American society which have supported the concept of market place competition and now are ready for corporate medicine. The supporters of this viewpoint feel that Americans will support this movement because it promises economic competition, lower prices and restraint of runaway health costs. They feel that our capitalistic heritage makes this concept viable and acceptable to Americans.

They are both right and wrong. They are right that the American people are ready for a change in the health care of this country. They are frightened by the rising costs and the seeming inability of the medical profession to hold costs down. They are wrong to think that the American people will accept corporate medicine in the manner it is being delivered or to allow the medical system to be permanently "incorporated."

From a social historian's point of view, I see a different scenario. The American people have been in favor of the corporate direction of medicine to this point. We tend to try to change things when we perceive that they are not working. From one viewpoint, the medical system was not working and something else should be tried. However, those who point to these reasons for the continued success of corporate medicine have failed to look at the other facets of the American character. Throughout our history we have experimented with many aspects of our society, but above all have maintained a firm belief in individuality, fairness and a desire to address perceived wrongs.

It is my feeling that corporate medicine will not be what the American people seek in the final analysis. True, it may cut costs, but at what price? Surely, all observers would agree that individualism has been subordinated to other factors. While the American people want to have economical medical care, I do not think they will accept a loss of their individual choices as an acceptable exchange. Americans will not accept a system that sets economics above all else. I know there are no studies to show that corporate medicine has led to decreased medical care, but I think there is no doubt that the level of medical care of this country will certainly not be the same in the future under corporate medicine. Americans also will not allow a system that leaves out the poor. It appears that corporate medicine has the potential to foster a two-tier system. One tier consists of those who are able to pay or have insurance and another tier consists of the medical indigent. Traditionally, the poor of this country have been taken care of by hospitals and physicians who by legal and moral reasons accepted this as part of the practice of medicine. The rise of corporate medicine threatens to leave the poor out of the medical system as profits are the bottom line and providing medical care without compensation is not "good business."

No, I think corporate medicine as we see it will not survive. I also think that medicine will never go back to what we knew prior to corporate medicine. What will evolve will be some of the elements which corporate medicine offers, such as cost restraints and strict utilization reveiw. Other factors which Americans cherish, such as freedom to choose individual physicians or methods of treatment, belief in fee for service — with some modification and controls — and available medical care for all Americans, regardless of ability to pay, will also reappear. The trend to corporate medicine and its eventual modification to a more traditional concept is in keeping with the American character to try to fix things that we perceive are not working and then to modify what has evolved. This change from corporate medicine will not come quickly and will probably take at least two decades before we work through this concept.

The American spirit simply will not let corporate medicine be the end result of the evolution of our system of medical care.

H. Frank Farmer, Ph.D. M.D.,
Historical Editor
New Smyrna Beach

A new team of arthritis specialists teams up.

Announcing Florida's Only Arthritis Treatment Center.

A complete team of multidisciplinary specialists, from physicians, nurses, occupational and physical therapists, to social workers, psychologists, pharmacists and nutritionists, will help your patients learn how to cope with their arthritis, lupus, scleroderma or other rheumatic disorders.

Together the team custom designs an individualized program for each patient. Their intensive inpatient program teaches patients how to exercise, avoid joint damage, and cope with the demands of daily living.

Other important members of the treatment team are the patients, their families and their personal physicians. We agree with other successful arthritis treatment centers across the country: teamwork brings results.



Our multidisciplinary treatment program, covers a wide range of activities. From nutritional and pharmaceutical counseling to physical and occupational therapy.

The Parkway Center for Arthritis and Rheumatic Diseases

"New Hope for Independent Living"

AMI Parkway Regional Medical Center

Thriving on Achievement

160 N.W. 170th Street,
North Miami Beach, FL (305) 651-1100

Introducing
New England Life
Government Securities Trust.*

It's worth looking into for:

Safety — The Trust invests in government securities which are prime investments carrying the highest possible credit rating.

High Yields — The Trust utilizes a special "high yield" strategy enabling you to earn additional income.

Liquidity — Shares of the Trust are redeemable at any time without penalty at the then current net asset value.

Professional Management — The Trust is managed by New England Life, one of the nation's largest financial institutions with over a century of experience managing fixed-income portfolios.

And More — Regular monthly income distributions, extra quarterly distributions, and membership in the New England Life Family of Funds . . . All for an initial investment of only $250 or $25 for your IRA or Keogh plans.

New England Life Government Securities Trust . . . any way you look at it, it's worth looking into.

New England Life

James E. Devaney
NEL Equity Services
701 Fisk Street
Suite 330
Jacksonville, FL 32204
(904) 356-3934

Make us your financial partner.

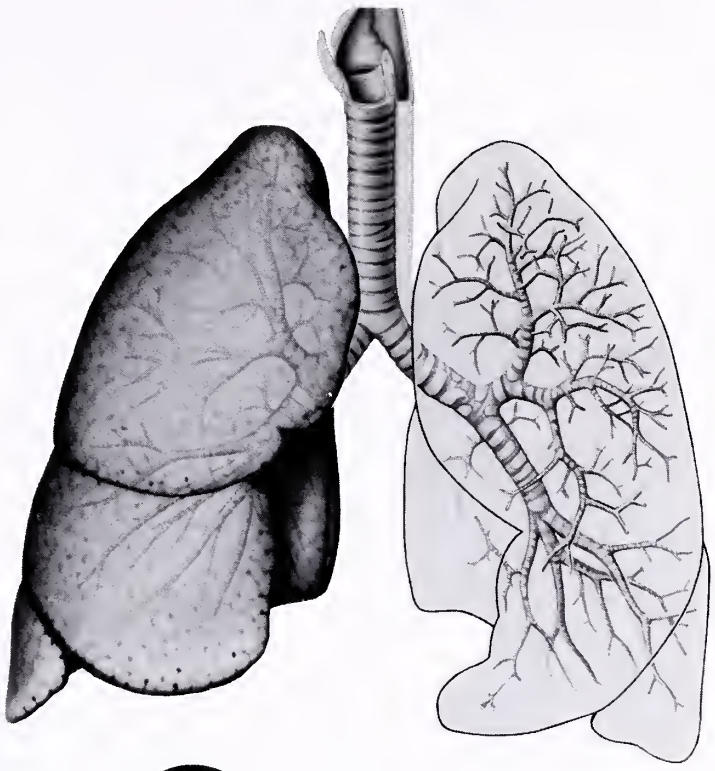


For more complete information about New England Life Government Securities Trust, including management fees, charges and expenses and to receive a copy of the prospectus, simply fill out and return the coupon. Read the prospectus carefully before you invest or send money.

Name _____
Address _____
City _____ State _____
Zip _____ Phone _____

*Offered through NEL Equity Services, Corp., an affiliate of New England Life.

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

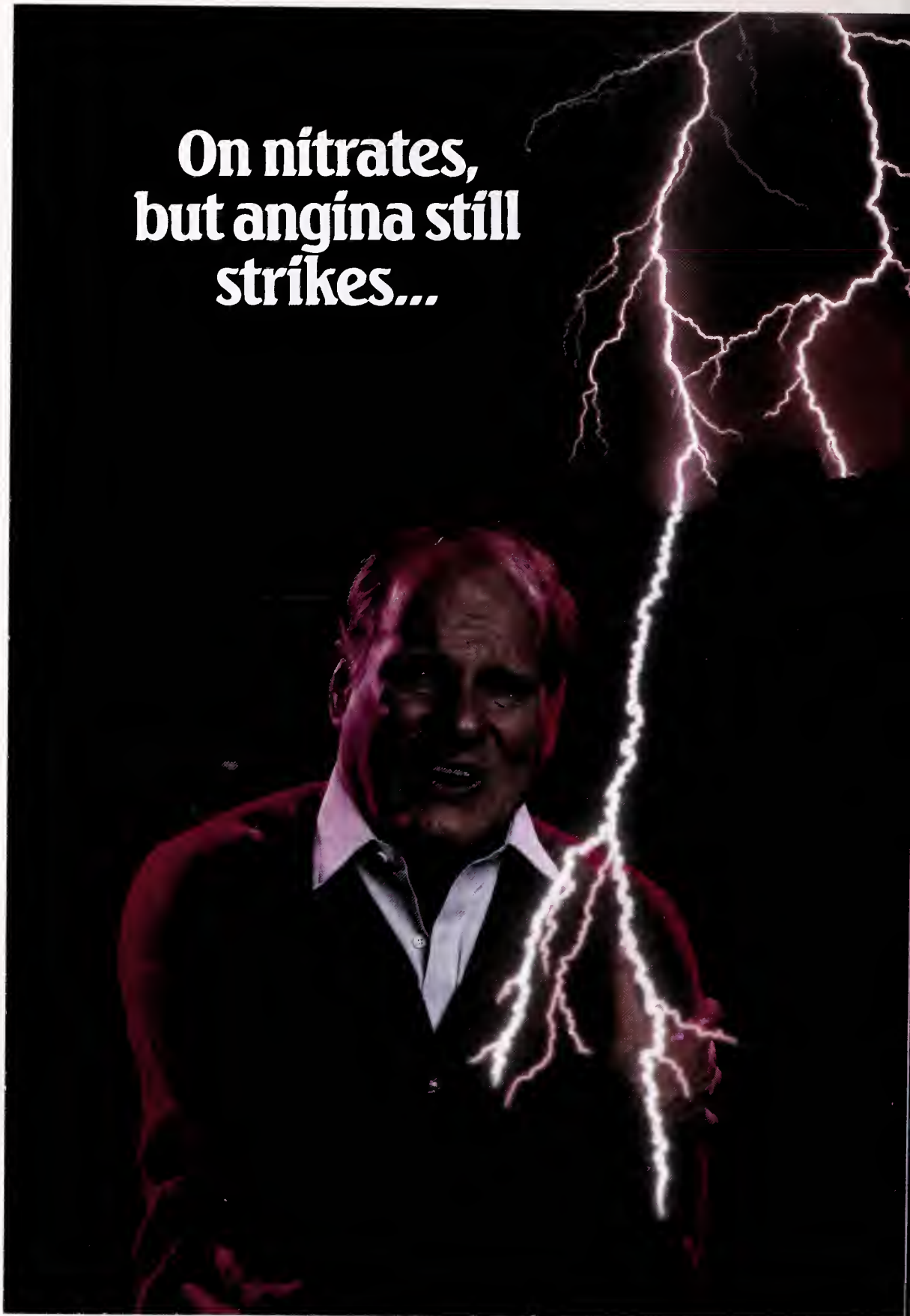
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

400441


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

knoll® **KNOLL PHARMACEUTICAL COMPANY**
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN. JUST ASK THE PEOPLE AT GEORGIA-PACIFIC.

"For me, buying Savings Bonds is an efficient way to save for a rainy day."
—Laura Schafer



"Savings Bonds allow me to put some money away before I get a chance to spend it."
—Rick Crews

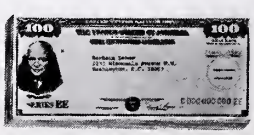


"Besides being a good investment in my country, Bonds help me save for my two daughters."
—Craig Heimbigner



U.S. Savings Bonds now offer higher, variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

Should pharmacists be allowed to dispense and prescribe?

Pharmacists are members of an esteemed and ancient profession who, in Florida as elsewhere, are educated and licensed to prepare and dispense medications for the treatment of human disease. In the not too distant past, pharmacists spent much of their time compounding medications for patients, but at present most medications are prepared by pharmaceutical manufacturers, leaving pharmacists to count, dilute, dispense, and label drugs according the physician's directions on the prescription.

A properly educated and competent pharmacist must fill prescriptions correctly, detect ones that are improperly written, substitute less expensive generic equivalents of brand name drugs, and advise physicians when a patient is taking drugs which may be incompatible with a new one prescribed.

Pharmacists may also offer advice to patients who are looking for a nonprescription drug to treat a particular disorder or symptom. Most people attempt to treat themselves for whatever medical condition may arise, for at least a week or two before deciding to seek the attention of a physician; such procrastination is only partially related to the cost of visiting a physician. Most people want to maintain control over their own bodies and spare themselves the anxiety that is often created by visiting a physician and possibly leraning bad news. Health surveys bear out that people wait for varying periods of time, even for an illness that they fear may be quite serious before making the decision to visit a medical doctor.

It was with both shock and dismay that I read that the Florida Legislature, the only state legislature in the nation to do so, granted pharmacists in this state permission to act like physicians: to examine patients, make diagnoses, and prescribe certain federally legended drugs: i.e., those that ordinarily require a physician's prescription. While physicians are educated and licensed to diagnose, operate, prescribe and dispense, it must be emphasized again that it is not within the education or training of pharmacists to examine patients, and to make diagnoses and prescribe.

As a dermatologist, whose specialty is being encroached upon by an ever enlarging variety of health care practitioners who believe they can treat skin disorders as well as someone who has completed a three year residency in that specialty, I am particularly offended by the Legislature's specific interest in making certain dermatologic medications, like lindane, available for use by pharmacists.

When I heard of the legislation, Chapter 85-35, written by House member and pharmacist Everett Kelly, (D-Tavares), a fantasy scenario immediately filled my imagination. It begins when a very itchy patient enters a chain store pharmacy in Miami or some other large city. He has been itching for three weeks, and has already tried four or five over-the-counter preparations without relief. He had worked himself up to the mind-set required to visit a physician, perhaps even a dermatologist, but a co-worker suggests that he make a professional visit to the pharmacist at the chain store near the supermarket. This patient, and in fact his co-worker, do not have any particular pharmacist in mind, but believe the young fellow with the little beard on the 3 p.m. to 11 p.m. shift might be pretty good.

Several possible scenarios emerged from my imagination at this point: in one, the pharmacist, a nice young man in his thirties, looks down from the pharmacy counter to the fully clothed itchy man and decides that he has scabies and orders lindane, a medication that he has been authorized to use by the Legislature. In a second possible scenario, the pharmacist steps down from behind the counter, and in

the busy and poorly lighted pharmacy aisle, among the parade of other customers and between the toothpaste and the laxative shelves, begins to examine the client, asking him in that public place to remove various items of clothing in order to fascilitate his inspection.

Along with this authority to examine patients and prescribe medications, the Legislature went along with Mr. Kelly's desire to allow pharmacists to bill third parties, not only for the medication, but for making the diagnosis as well. Mr. Kelly professed that his legislation was intended to "save Joe Lunchbucket or Jane Q. Public the $30.00 charged by the average physician for an office visit," but his legislation will not save us all from charges made to third parties by pharmacists who are trying to play doctor, although they lack the expertise and credentials to do so.

In a typical legislative ploy to cover themselves while they transgress into the domain of a properly educated and licensed profession, the Florida Legislature created a joint committee, which is authorized to determine which other prescription drugs pharmacists are entitled to use, in addition to those already spelled out in the legislation: lindane, flouride, antihistamines and decongestants. Naturally, three of the six joint committee members are pharmacy board members, stacking power on the side of those who would perhaps make all pharmacists into physicians.

Misery certainly loves company, and in our wonderfully litigious society, I expect and perhaps even secretly hope that certain agressive pharmacists and perhaps even the Legislature will get their just dessert for having foolishly, and perhaps even maliciously, given legal authority to one profession to perform the services of another.

The personal injury implications of this legislation created another scenario, in which the patient is again standing in a dimly lighted pharmacy, and from a distance of about 8 feet the pharmacist determines that the poor man has scabies and needs lindane. My fantasy, (or nightmare, according to your point of view), continues with the patient going home and either ingesting the lindane, and suffering a serious and perhaps even fatal case of chemical hepatitis, or applying it properly but developing an anaphylactic reaction and dying. It would be shown at autopsy, the dream continues, that he never actually even had scabies, but some other dermatitis. In addition, he had once before demonstrated an allergic reaction to lindane, which gone undetected by the pharmacist. The scenario concludes when the grieving young widow and her eight preschool age children sue the pharmacist, the drug store chain, and perhaps even the Legislature for their actions which culminated in the young man's premature demise.

In reality, I do not imagine any significant impact on the practice of either medicine or pharmacy from this particular legislation. The few drugs authorized in the law are generally safe and I believe that the joint committee will become mired down in partisan issues, and will accomplish very little. Most pharmacists are content with their own profession, and have no desire to practice medicine, a profession with greater celebrity status, but one whose members are plagued with significantly more anxiety and despair.

The serious consequences of this legislation concern the audacity of our Legislature to grant individuals power for which they lack the education and training, and its passage establishes a precedent for the wanton disregard of traditional values by our state leaders, while producing very little, if any benefit to anyone. A rational way to have solved this problem could have involved the creation of a joint committee to find those prescription drugs which could be made nonprescription, so that pharmacists could counsel store customers on their usage, rather than authorizing pharmacists to behave like physicians, which they are not.

Richard J. Feinstein, M.D.
Contributing Editor
Miami

Save us from the doctors?

The editorial reprint, "What kind of justice is this? Save us from the lawyers" would have been better captioned "Save us from the doctors and corporations." It is indeed strange when the writer of the editorial mentions several rather horrendous medical results certainly not caused by lawyers and yet concludes that it is the lawyers from which we need to be saved. His bias is certainly showing when he admits that filing for bankruptcy by Robbins in the Dalkon Shield cases is a dirty trick, but then proceeds to say, "Who can blame them?" Certainly he is charitable towards the wrongdoer. His bias is certainly evident when he then proceeds to castigate the only profession that stands up for the helpless victim in an otherwise hopeless struggle against the physicians and giant corporations: the lawyers.

What would happen if there were no lawyers to represent injured patients? This article contains the answer. There were 49 deaths in the Oraflex cases. The government fined the company a total of $25,000. Let the people choose which system they would prefer.

The author there commits a common error. He somehow equates a demand for a damage amount ("suing for") with an actual recovery. Rarely is a

recovery ever close to the demand made in the complaint. Just because there is a claim filed does not mean that there will be that kind of recovery. Even if there is a large verdict by a jury, that does not mean it will ever be collected. Consider the celebrated $14 million verdict obtained in Broward County for a totally helpless victim. That verdict was overturned on appeal. All the publicity that went with the verdict has made its impression. Not many people know that the victim has received not one penny of that money, nor has the lawyer. The case will have to be retired.

I think it is significant that Mr. Knight (the writer of the editorial) ends his article with the impotent and totally unhelpful suggestions "there must be a better way." If there is a better way, let him suggest it. In most cases, the "better way" has ended up being the worse way. The simple tort system with trial by a jury is the best tool of justice the world has devised. Far from perfect, but also far better than being at the mercy and caprice of an all powerful government with its hopeless bureacratic morass.

The medical profession may soon have to decide whether it wants to pay for its mistakes in the tort system or surrender to government control. When the government pays your bill, then the government also will pay for the mistakes. However, your cherished freedom disappears at the same time. This is probably the decision the medical profession is facing now. With government protection comes government control. That control means control of practice as well as income. Take your choice.

Walter C. Ward, M.D., J.D.
Miami

Editor's reply: Dr. Ward apparently missed the entire point of the editorial. Mr. Jerry Knight, who wrote the editorial originally for the *Washington Post*, was decrying the current tort system and all the evils that it has bred in American society. It is a system that invites people to sue at the drop of a hat, making adversaries of us all, costing billions of dollars, and dispensing justice neither to the plaintiffs nor to those who are sued. The lawyers, as everybody knows, are the only winners. There is only a vestige of justice when even those who need to be recompensed for their injuries end up with outrageous and unconscionable awards, with the lawyers of course sharing in the booty.

Mr. Knight was so right in stating that ". . .lawyers are largely responsible for the entire nation's befuddled view of how victims of wrongs should be compensated." No other nation in the civilized Western world dispenses justice with the kind of brutal tort system that we have here.

Dr. Ward perceives that physicians will now have to choose between paying for their "mistakes" in the tort system and surrendering control of their profession to the government. That is an arrogant and self-serving view of the problem. Dr. Ward surely must now be aware that the evils of the current tort system have about pervaded every segment of American society, making liability protection extremely expensive and sometimes unavailable. If the government intervenes by way of federal legislation to curb the abuses of the system, as it is planning on doing, it will no doubt be good for the public, but bad for the lawyers.

Is there a better way than the lawyer-to-lawyer combat we now see with our current tort system? Certainly. Many sensible suggestions have been made through the years, including one repeatedly made by Chief Justice Warren Burger but consistently ignored by the lawyers, and that is the use of more arbitration. That, of course, would drive many lawyers out of business.

A new life after by-pass surgery

I am reminded of a patient's remarks after we Americans landed on the moon. She said, "They better leave God's moon alone."

This attitude could be just as appropriate for tinkering with the human heart, which everybody knows is the sine qua non of life itself. I must confess that a number of us are influenced by superstition. As someone who has had to learn anatomy and physiology of the most remarkable organ of our body, I have always felt too much awe for it to be handled with anything except the most careful respect. It most nearly approaches perpetual motion than any other portion of our machinery. When all other organs are allowed periods of rest, it must function day and night, awake or asleep, active or inactive, conscious or unconscious. At seventy-seven years of age, I often pat my chest and say to my heart, "Old boy, you have done and are doing a wonderful job." My gratitude to nitroglycerin and by-pass surgery may yet cause it to swell and burst.

For ten years before July, 1984, I was having episodes of angina and had progressed to the stage of having to take a nitroglycerin tablet after walking a half block or after any mild emotional stimulus. That little pill, by the way, was more valuable to me than all the diamonds in Africa.

When catheterization showed significant obstruction in three of my major coronary vessels and partial occlusion of my left femoral artery, I had a triple by-pass operation in July of 1984 and femoral dilation. My awe of the heart and its function did not give me a moment's hesitation in opting for the

surgery. I took this as an excuse to retire from active practice. The operation was an outstanding and remarkable success.

This last year and a half has been the most enjoyable time of my life. Do not let anybody tell you that a workaholic physician with fifty years of service under his belt cannot enjoy retirement.

I am not taking medication of any kind. I have discovered the joys of the privacy, liberty and relaxation of my home. I can relish more opportunities for the companionship and friendship of my wife, children and former patients. I have been active in more civic affairs and in church work. With the present need for volunteer services to help our country's need for cost containment, I can have just as much work as I want. I have been able to indulge in cultural activities which have previously been only objects of envy to me and beyond my grasp. They include art, literature, music and travel. Recreation including fishing and golf contribute even more to my joy of living. Who could ask for anything more?

H. L. Harrell Sr., M.D.
Ocala

THE PHYSICIAN'S ATVANTAGE

FUTURE transforms the IBM PC AT into a nine-user system to manage your practice.

Now FUTURE Information Systems offers the ATvantage that lets you practice medicine instead of accounting: Computone's powerful combination of Medical Office Management System software and AT expansion hardware. The total system that provides everything you need to automate your office from one of the country's fastest-growing computer dealers.

You can build a single IBM PC AT into a nine-user multi-tasking system with the AT ATvantage board, using any IBM PC, PCjr or inexpensive stand-alone terminals you may already own.



You can reduce paperwork with easy-to-use Medical Office Management System software, designed to let your staff enter or access information and simultaneously perform up to five related functions. Many accounting and management control operations are automatically updated with patient entry and posting.

And you can do it all with FUTURE beside you every step of the way, providing in-house or on-site training, complete hardware and software maintenance and continuous support.

Get the Physician's ATvantage working for you. Contact FUTURE Information Systems today.

Features of the Physician's ATvantage:

- ☐ Instant access to patient balance, insurance submission and insurance payment information
- ☐ Open-item patient accounting
- ☐ Patient statements and "Super-bill"
- ☐ Third-party insurance processing
- ☐ Patient/guarantor relationships
- ☐ Insurance rebilling or write-off
- ☐ Cash flow control
- ☐ Patient history
- ☐ Problem accounts
- ☐ Accounts receivable reductions of 20-50%
- ☐ Patient referrals
- ☐ Appointment scheduling
- ☐ Automatic audit trails
- ☐ Single doctor office, or several
- ☐ Multi-office practices

FUTURESM
INFORMATION SYSTEMS
A Computone company

MOVING YOU UP IN THE WORLDSM

Pensacola: Cordova Square, 400 Bayou Blvd., Suite 49 • (904) 474-9855
Ft. Walton Beach: 514A Mary Esther Cutoff • (904) 244-8675
Other computer showrooms in a growing number of U.S. cities.

IBM PC, IBM PCjr and IBM PC AT are trademarks of International Business Machines Corp. ATvantage is a trademark of Computone Systems Inc.

A WORD TO THE WHYS

WHY AMA?

The AMA has tackled the issue of cost effective quality medical care by supporting the development of health care coalitions. The Association believes the best mechanism for keeping health costs down without sacrificing quality or accessibility is through voluntary coalitions in which physicians actively participate. Working to promote high quality, affordable medical care in the United States: it's one more good reason why you should be a part of the AMA.

WHY AMA?

The AMA has actively sought to attract women as members and leaders in organized medicine. Ongoing AMA projects and concentrated efforts by county, state, and specialty societies have significantly increased the leadership role and membership of women in organized medicine. Strengthening the voice of women in medicine through encouraging active participation: it's one more good reason why you should be a part of the AMA.

WHY AMA?

Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and microfilm and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
DECEMBER 1985, Vol. 72, No. 12

Screening for diabetes mellitus

Arlan L. Rosenbloom, M.D., John I. Malone, M.D., Anthony D. Morrison, M.D., and Jay S. Skyler, M.D.

ABSTRACT: Testing blood specimens for glucose level has long been a highly visible activity of voluntary groups. Such casual testing, however, lacks specificity as well as sensitivity and is difficult to consider as a public service. Even if it was reliable and follow-up assured, there is no evidence that early detection of asymptomatic diabetes is associated with improved outcomes. Recommendations of the 1978 Atlanta Workshop on Screening remain valid: general population testing is not recommended, case-finding in pregnancy should be routine, screening for diabetes should only be part of a well-designed focus on high-risk populations or research questions, and monitoring of known patients for complications of diabetes should be done.

The Authors
ARLAN L. ROSENBLOOM, M.D.
JOHN I. MALONE, M.D.
ANTHONY D. MORRISON, M.D.
JAY S. SKYLER, M.D.
Dr. Rosenbloom is Professor of Pediatrics and Director of the Diabetes Research, Education and Treatment Center at the University of Florida College of Medicine, Gainesville; Dr. Malone is Professor of Pedicatrics and Codirector of the Diabetes Center at the University of South Florida College of Medicine, Tampa; Dr. Morrison is Associate Professor of Medicine, Codirector of the Diabetes Center at the University of South Florida College of Medicine, Tampa; and Dr. Skyler is Professor of Medicine and Pediatrics and Director of the Diabetes Center at the University of Miami School of Medicine.

The inherent value of screening the population for hyperglycemia has long been an article of faith and a cornerstone of voluntary health agency activity. However, in 1974 the American Diabetes Association stopped advising routine screening of school children as a chapter activity,[1] and the Atlanta Workshop of 1978 recommended that only highly circumspect screening for the adult population be applied.[2] Nonetheless, people active in lay and professional associations continue to promote and support screening in the hope that it is of value to the community. Is there any evidence that screening is of value for communities? In order to answer this question we need to review the natural history of diabetes, the qualities of screening, and the evidence that intervention at an early stage affects morbidity and mortality in diabetes.

Natural history of diabetes mellitus • In 1979 the National Diabetes Data Group (NDDG) adopted a classification of diabetes and other categories of glucose intolerance which has proved useful for communications among investigators and for standardization of epidemiologic data.[3] The conditions defined in this classification include: insulin-dependent diabetes mellitus (IDDM), noninsulin-dependent diabetes mellitus (NIDDM), other types of diabetes due to pancreatic disease, hormonal abnomalities, drug toxicity, etc. (secondary diabetes), impaired glucose tolerance (IGT), and gestational diabetes and impaired glucose tolerance in pregnancy. This classification has certain theoretical and practical problems because it is based partially on etiology and partially on degree of impairment. The classification was devised to reduce confusion but substantial numbers of patients continue to fall

between categories. In spite of these shortcomings the adoption of this classification has markedly improved scientific communication. The criteria for diabetes were based on bimodality of responses to a standard glucose load in a population with a high prevalence of NIDDM (Pima Indians);[4] the appropriateness of these criteria has recently been confirmed in a different population.[5]

The stages in the natural history of diabetes apply regardless of etiology. First is the stage of susceptibility which could be based on either genetic risk (e.g., HLA-identicality with an IDDM sibling or monozygotic twin of a NIDDM patient) or falling into a high-risk population due to race, obesity, or pregnancy history (large babies). The next phase is glucose intolerance which we now recognize to be a phase of IDDM as well as NIDDM. Between susceptibility and glucose intolerance, reduction in early phase insulin release to IV glucose can be demonstrated in IDDM. Not all those with IGT progress to symptomatic diabetes. The third phase of the natural history is diabetes mellitus without complications; the fourth phase diabetes with complications but without disability due to them. The last phase is diabetes with disability due to functional impairment from the complications including end-stage renal disease, blindness, neuropathy, cerebral vascular disease, peripheral vascular disease or cardiac disease. The theoretical basis of screening is that detection at the stage of impaired glucose tolerance or early diabetes without symptoms can lead to intervention that will prevent or forestall progression to the more morbid stages. Before this issue is considered, we need to look at the characteristics of screening.

Characteristics of screening ● Much of the controversy surrounding screening in general and diabetes screening in particular comes from confusion about the definition of screening and its goals. Three activities that resemble screening need to be defined: epidemiologic survey, casefinding, and diagnostic testing.[6]

Screening involves the testing of apparently unaffected volunteers in order to categorize them into those that are likely or unlikely to have the condition in question. There is an implicit promise of health benefit to the volunteer who has been screened.

The epidemilogic survey measures demographic, social, behavioral, and biologic characteristics of representative samples of carefully selected populations. These measurements may be unrelated to specific disease entities and their objective is that of acquiring new knowledge. Although health benefit may derive indirectly from an epidemiologic survey, no specific health benefit is implied.

Casefinding is often confused with screening. Casefinding is the testing of patients who have sought medical service for other reasons. Although the testing of all pregnant women for diabetes is frequently referred to as screening, it is really casefinding. This distinction is important because casefinding is part of comprehensive, community-standard practice. It is directed to a high-risk population and reflects the judgment of the attending physician that a certain group of patients should be routinely examined in a specific way. This is quite distinct from a screening program where the volition is that of the volunteer.

Finally, diagnostic testing is the application of various questions, examinations, and tests to patients in order to identify the exact cause of their chief complaints. Although a participant in a survey, volunteer in a screening program or recipient of casefinding may be seeking diagnosis, the purpose of their testing is not specifically diagnostic. If there are positive results for the study in question, diagnostic testing would then be appropriate.

Requirements of a screening program ● The first requirements for a screening program is that there be a relevant test available which is predictive. Random blood glucose determinations are difficult to interpret in a screening program because the glucose level is affected by time of day, duration of fasting, concomitant illness or stress, as well as glucose tolerance. The NDDG criteria are based on fasting and postglucose loading levels over a 2-hour period.[3] If screening was confined to fasting blood glucose levels, diagnosing diabetes when the fasting level is over 140 mg/dl, consistent with NDDG and WHO criteria, only 13% of those diagnosed as having diabetes by a full 2-hour GTT would be detected.[7]

Another requirement of a screening program is that the condition be perceived as serious by the target group. In most populations, this is true of diabetes in a general sense, but how seriously individuals regard "a touch of diabetes," i.e., asymptomatic disease that has been detected by screening and subsequent diagnostic testing, remains to be established.

High prevalence is another condition for a successful screening program. The low prevalence of IDDM and its explosive clinical onset (despite long latency demonstrable by impaired glucose tolerance and islet cell autoimmunity) were principal reasons for abolishing screening of school children. The prevalence of diabetes increases with age and is higher in females and Blacks in the U.S. It is estimated that 8.5 million persons have diabetes in the age group 20 to 74 years, based on the recent Second National Health and Nutrition Examination Survey (NHANES II).[7] However, as noted in the NHANES II study,[7] detecting the asymptomatic group that accounts for approximately half the

Table 1. — Methods in Screening For Diabetes.[14]

	SENSITIVITY	SPECIFICITY	COST
Urine			
Fasting	Very Poor	Fair	Inexpensive
Postprandial	Fair	Mediocre	Inexpensive
Casual	Poor	Fair	Inexpensive
Blood/Plasma			
Fasting	Fair	Good	Intermediate
Postprandial	Good	Good	Intermediate
Measured Load (Cola, Glucose)	Very Good	Very Good	More Costly
Casual	Fair	Fair	Intermediate

estimated diabetic population in the U.S. requires measures beyond screening.

A fourth requirement for a screening program is that community resources be available for follow-up of the individuals tested positive. It is unusual for a voluntary screening program to assure such follow-up, but it is not ethically proper to carry out a screening program in the absence of such a system.

The most difficult requirement of a screening program is that treatment be available for the condition identified which is more effective when given in the presymptomatic period than in the clinically symptomatic period. Looking first at impaired glucose tolerance, it is estimated from the NHANES I survey that 4.7% or 7 million Americans aged 20 to 74 years have IGT.[7] Data from England suggest that approximately 1/5 of them will develop diabetes over the subsequent decade.[8,9] However, over half will actually experience improvement in their impaired glucose tolerance. In some studies, the degree of obesity may be related to the rate of decompensation[10,11] but there is no evidence that knowing about the impaired tolerance motivates patients to lose weight. There is also no evidence that oral hypoglycemic agents have a substantial long-term effect,[8,12] and their use would seem to be unwarranted for asymptomatic diabetes in view of the low rate of progression to frank diabetes and their lack of benefit in overtly diabetic populations.

Detection at the stage of asymptomatic diabetes has had no beneficial effect on morbidity or mortality in the Pima population[4] or in the population studies by the University Group Diabetes Program,[13] which led to the conclusion that "the UGDP findings provide no evidence that insulin or any drug lowering blood glucose levels will alter the course of vascular complications in adult-onset diabetes."

Properties of screening • The properties of screening include simplicity, acceptability, cost, precision, accuracy, specificity, sensitivity, and predictive value. The last three require definition:

1. Specificity is the percentage of disease-free individuals who are screened to be negative by the test.

2. Sensitivity is the percentage of individuals with disease who are screened to be positive by the test.

3. Predictive value is the percentage of positive or negative individuals who have disease or who are disease-free.

West[14] has outlined the sensitivity, specificity, and cost properties of various methods used in screening for diabetes (Table 1). As we have already indicated, a measured load of glucose applied under standardized conditions provides the greatest sensitivity and specificity but is obviously the most costly and difficult approach.

The WHO expert committee on diabetes mellitus in its second technical report stated that screening should always be accompanied by cost-benefit analysis.[15] This is rarely accomplished. In particular indirect cost to the individuals, work loss, and cost of additional medical care are seldom included. The direct costs alone for each new case of diabetes detected in screening programs were estimated by West[14] in 1978 to vary from $35 to $67 with indirect costs taking this well over $150. In 1985 dollars this figure would have to be doubled or tripled.

Advantages and disadvantages of screening • The advantages of screening include:

1. Opportunities for education of the public about diabetes.

2. Early detection before development of symptoms with possible prevention of morbidity and mortality from complications.

3. Prestige for the organizations involved in the screening program.

4. Fund raising opportunities for the organization providing the screening.

5. Research possibilities.

The preceding discussion has brought into question only the second point. It needs to be reemphasized that diabetes casefinding in pregnancy has specifically been excluded by our definition of screening as have studies of first degree relatives of youngsters with IDDM or early stages of diabetes.

The disadvantages of screening are:

1. Expense, both programmatic and individual.

2. Lack of evidence that early detection has an impact on long-term outcome in the population.

3. Limited resources for follow-up in many areas, raising the questions of cost-benefit and ethics of screening.

4. The psychological hazards of false positives.

5. The danger of missed diagnosis because of low sensitivity of the testing procedure (e.g., fasting blood glucose levels as noted previously).

Some of these factors can be altered by confining screening to particularly high-risk groups as was suggested by the Atlanta Workshop.[2] This would include the obese, those, with a family history of diabetes, nonpregnant individuals with an obstetrical history of large babies, those in high-risk populations such as Pima Indians or Blacks, and as part of studies of multiple risk factors in cardiovascular disease. By confining screening programs to high-risk populations, the advantages of screening are affected as follows:

1. Public education may be diminished for the public at large but increased for the population screened because of the greater concentration of effort.

2. Early detection with the possibility of preventive intervention might be enhanced by a more focused program.

3. The prestige of the reduced program is also likely to be reduced unless dramatic effects are demonstrated and can be publicized.

4. The fund raising potential of a focus on high-risk groups is reduced.

5. The research potential of a focused screening program should be enhanced.

In a program confined to high-risk groups some of the effects of screening would be:

1. Expenses would be reduced.

2. Intervention via early detection would probably be no better as evidenced by the lack of any evidence for improved outcome among Pima Indians despite extensive screening in that population.[13]

3. Although the limited resources for follow-up might be taxed, the higher yield in a smaller population might still make follow-up difficult.

4. The psychological effects of false positive tests would be similar in a high-risk group screening but would involve fewer individuals and could probably be dealt with more effectively.

5. Missed diagnoses due to false negative tests would be similar but fewer in high-risk group screening.

Conclusions ● The recommendations of the Atlanta Workshop remain valid although they reflect a mixture of screening, casefinding, and diagnostic testing. The first recommendation was for "screening" among pregnant women which, as previously noted, is really casefinding as part of good obstetrical practice.

The second recommendation of the Atlanta Workshop was that screening programs to detect asymptomatic glucose intolerance per se are not recommmended as health services in nonpregnant populations.

The third recommendation was that screening for diabetes or its complications for research purposes should be done only as part of a well-designed focus on (a) identification of predictive factors, (b) cost effectiveness of the measures to lower risk factors, (c) descriptive epidemiology in selected populations, (d) operation of the medical care system, and (e) nature and effects of screening processes.

The fourth recommendation was that information and educational programs for health care providers, parents, and the general public should be implemented to bring about increased awareness of the clinical signs and symptoms of diabetes. This recommendation was offered as an alternative to the public education and promotion of diabetes programs thought to be an advantage of screening efforts.

The final recommendation of the Atlanta Workshop quite properly falls in the area of casefinding as well, that all persons known to have diabetes be evaluated regularly for the detection and management of the chronic complications of the disease.

In view of the very limited value of random blood testing for glucose as a means of detecting diabetes, such testing does not provide a public service.

References

1. Rosenbloom, A.L. and Allen, C.M.: Mass Urine Glucose Screening in Children, Metabolism 22(2):323-326, 1972.
2. Herron, C.A.: Screening in Diabetes Mellitus: Report of Atlanta Workshop, Diabetes Care 2:357-362, 1979.
3. National Diabetes Data Group: Classification and Diagnosis of Diabetes Mellitus and Other Categories of Glucose Intolerance, Diabetes 28:1039-1057, 1979.

4. Bennett, P.H.; Rushforth, N.B.; Miller, M., and LeCompte, P.M.: Epidemiologic Studies of Diabetes in Pima Indians, Recent Progr. Horm. Res. 32:333-371, 1976.
5. Rosenthal, M.; McMahan, C.A.; Stern, M.P.; Eifler, C.W.; Haffner, S.M.; Hazuda, H.P., and Franco, L.J.: Evidence of Bimodality of Two Hour Plasma Glucose Concentrations in Mexican Americans: Results from San Antonio Heart Study, J. Chron. Dis. 38(1):5-16, 1985.
6. Sackett, D.L. and Holland, W.W.: Controversy in Detection of Disease, Lancet ii:357-359, 1965.
7. National Center for Health Statistics: Plan and Operation of Second National Health and Nutrition Health and Nutrition Examination Survey 1976-80. Vital and Health Statistics Series 1(15)DHHS Publication N. (PHS)81-1317, Public Health Service, Washington, U.S. Government Printing Office, July 1981.
8. Jarrett, R.J.; Keen, H.; Fuller, J.H., and McCartney, P.: Worsening to Diabetes in Men with Impaired Glucose Tolerance ("borderline diabetes"), Diabetologia 16:25-30, 1979.
9. Keen, H.; Jarrett, R.J., and McCartney, P.: Ten Year Follow-up of Bedford Survey (1962-1972): Glucose Tolerance and Diabetes, Diabetologia 22:73-78, 1982.
10. O'Sullivan, J.B. and Mahan, C.M.: Blood Sugar Levels, Glycosuria and Body Weight Related to Development of Diabetes Mellitus, JAMA 194:117-122, 1965.
11. Knowler, W.C.; Pettitt, D.J.; Savage, P.J., and Bennett, P.H.: Diabetes in Pima Indians: Contributions of Obesity and Parental Diabetes, Am. J. Epid. 113:144-156, 1981.
12. Keen, H.; Jarrett, R.J., and Fuller, J.H.: Tolbutamide and Arterial Disease in Borderline Diabetics, Proc. VIII Congress International Diabetes Federation, Malaisse, W.J. and Pirart, J. (eds), Amsterdam, Excerpta Medica, 1973, pp. 588-602.
13. University Group Diabetes Program: Effects of Hypoglycemic Agents on Vascular Complications in Patients with Adult-Onset Diabetes, VII Evaluation of Insulin Therapy, Final Report, Diabetes 31(Suppl. 5):1-81, 1982
14. West, K.M: Epidemiology of Diabetes and Its Vascular Manifestations, Elsevier (New York) 1978, pp. 54-67.
15. WHO Expert Committee on Diabetes, Second Report: Technical Report Series 646, World Health Organization, Geneva 1980.

Supported by contracts from the Department of Health and Rehabilitative Services of the State of Florida for Diabetes Centers at the Universities of Florida, South Florida, and Miami.

● Dr. Rosenbloom, Department of Pediatrics, Division of Endocrinology, University of Florida College of Medicine, Box J-296, JHMHC, Gainesville 32610.

Endorectal irradiation — conservative therapy for cure of early rectal cancers

Barry S. Tepperman, M.D. and Herbert E. Brizel, M.D.

ABSTRACT: Contact endorectal irradiation is a conservative, ambulatory treatment for early rectal cancers. In properly chosen patients, it offers cure rates comparable to radical resection while sparing the sphincters and surgical and anesthetic risks. In our experience, it is a well-tolerated, cost-effective and simple alternative to hospitalization and resection.

The Authors
BARRY S. TEPPERMAN, M.D.
HERBERT E. BRIZEL, M.D.
Drs. Tepperman and Brizel are with Memorial Hospital Regional Radiation Oncology Center, Hollywood, and also with the Division of Radiation Oncology, Department of Radiology, University of Miami, Miami.

Adenocarcinoma of the rectum is the third most common cause of cancer death in Florida.[1] The mainstay of curative management is surgical. For the patient who is medically inoperable or who is incapable of managing a colostomy, alternatives to surgery are indicated. These include local excision, cautery, and irradiation. All require strict clinical selection of patients most likely to benefit. Ideally a conservative nonsurgical treatment for rectal carcinoma should require neither hospitalization nor general anesthesia, have no intrinsic risk of mortality and a low risk of complication. It should avoid a colostomy and provide prospects of durable local control comparable to limited surgery. Finally it should not compromise surgical salvage in cases of failure.

Endorectal contact irradiation was developed in its present form by Professor Jean Papillon in France over 30 years ago.[2] North American experience dates from the late 1960s.[3,4] The "Papillon technique" satisfies all the above criteria and in properly selected patients offers both compliance and efficacy.

Therapeutic rationale • As demonstrated by local control with external radiation alone,[5] rectal adenocarcinoma is radiosensitive. However, the adjacent structures which must be included in the treatment volume for curative external irradiation of large or advanced lesions are also radiosensitive, and the high dose required to sterilize rectal cancer may cause unacceptable morbidity to the small intestine or bladder.[6]

A more tolerable treatment strategy requires a high radiation dose delivered to a precisely controlled limited volume. In endorectal irradiation the dose is delivered maximally on the surface of the tumor and

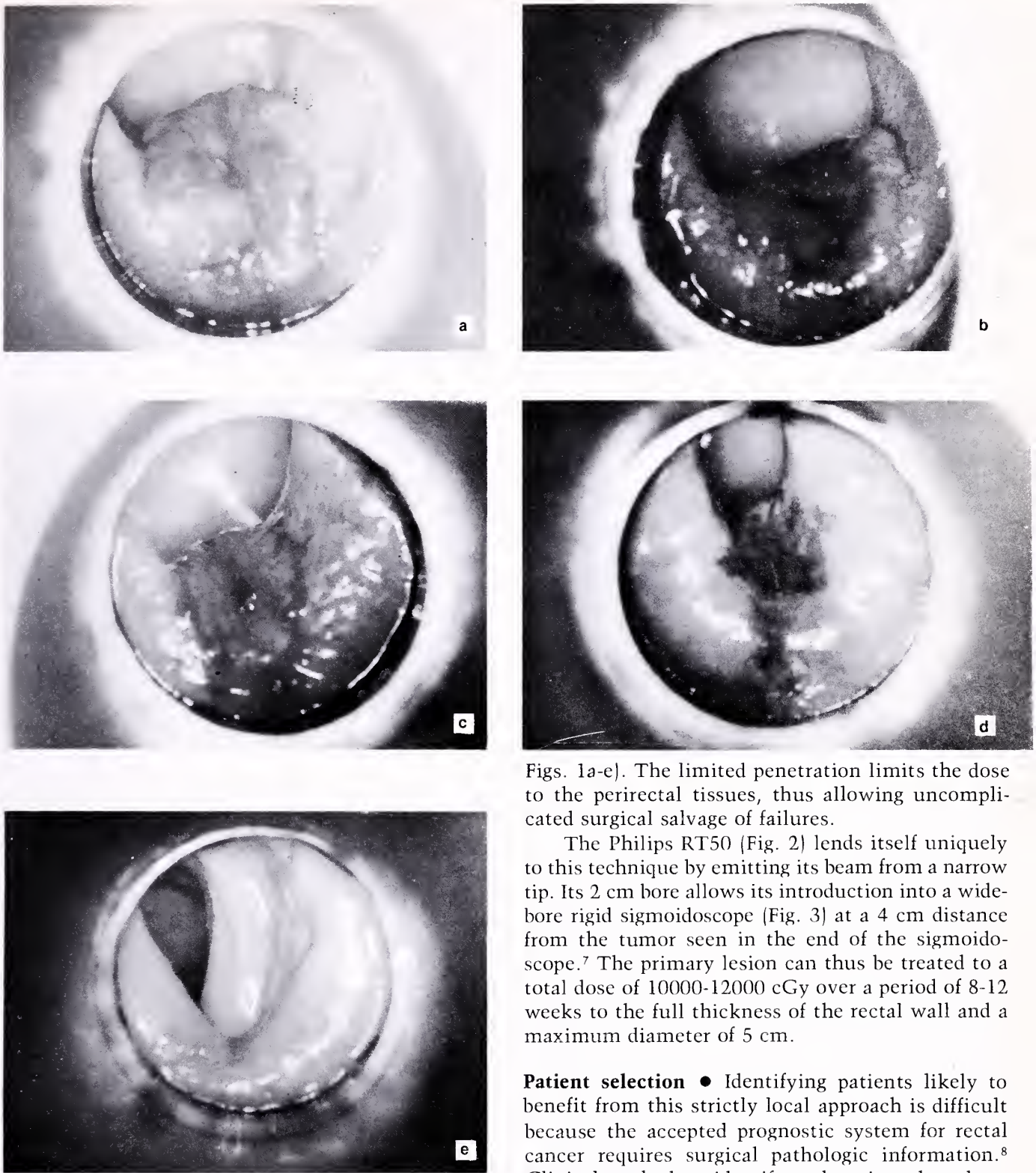


Fig. 1. — Regression of an exophytic lesion in response to endorectal irradiation: (a) before treatment; (b) after 2000 cGy; (c) after 4000 cGy; (d) after 6000 cGy; (e) after 10000 cGy (completed therapy).

decreases rapidly with depth in the rectal wall. While the visible lesion necroses during the course of therapy (5-6 fractions of 2000-3500 cGy each at 2 week intervals), the dose at depth increases progressively, ultimately sterilizing the tumor base (Figs. 1a-e). The limited penetration limits the dose to the perirectal tissues, thus allowing uncomplicated surgical salvage of failures.

The Philips RT50 (Fig. 2) lends itself uniquely to this technique by emitting its beam from a narrow tip. Its 2 cm bore allows its introduction into a wide-bore rigid sigmoidoscope (Fig. 3) at a 4 cm distance from the tumor seen in the end of the sigmoidoscope.[7] The primary lesion can thus be treated to a total dose of 10000-12000 cGy over a period of 8-12 weeks to the full thickness of the rectal wall and a maximum diameter of 5 cm.

Patient selection • Identifying patients likely to benefit from this strictly local approach is difficult because the accepted prognostic system for rectal cancer requires surgical pathologic information.[8] Clinical methods to identify such patients have been systematized by Papillon on the basis of Morson's clinical-pathological correlations.[2,9] The essential criteria are lesion configuration, size, location, and multiplicity, pathologic grade, and fixation, and the presence of palpable perirectal nodes.

The ideal lesion for endorectal irradiation is a single polypoid, mobile, well-differentiated adenocarcinoma under 3 cm in diameter (risk of regional metastases<6%) located between 3 and 12 cm above

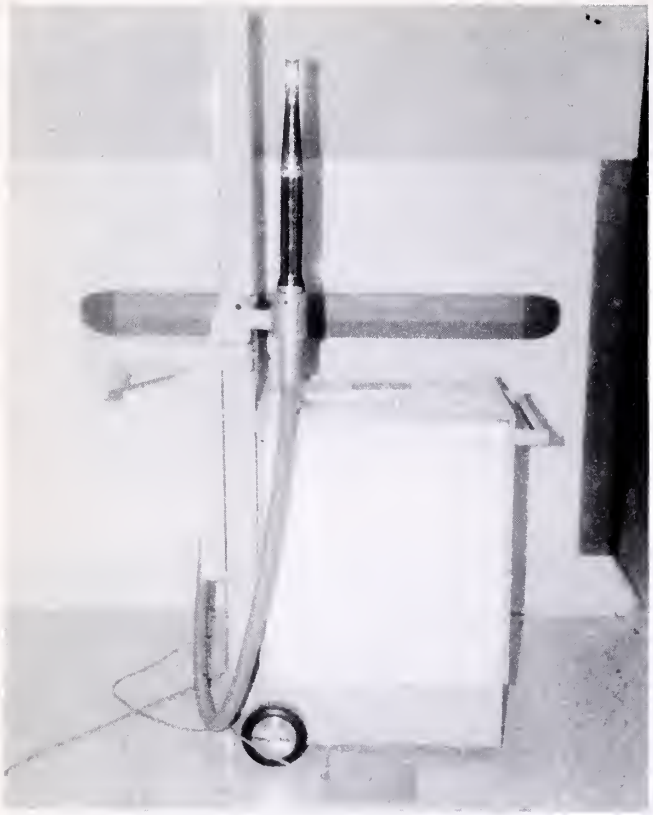


Fig. 2. — The Philips RT50 contact therapy unit.

the anal margin without palpable perirectal adenopathy. It presents an anticipated cure rate of 90-95%.[2] Poorly-differentiated or colloid adenocarcinomas present an excessive risk of regional spread (>25%). In lower-grade tumors the risk of nodal spread increases when the carcinoma is ulcerative or infiltrative, or with lesions larger than 3 cm. A fixed carcinoma — either clincally or by CT scan — penetrates too deeply to be sterilized by this superficial beam. Lesions which are multifocal, annular, greater than 5 cm in diameter or above the 12 cm level in the rectosigmoid physically exceed the curative capabilities of this modality. Lesions below the 3 cm level involve a significant risk of sphincter necrosis by irradiation. Palpable perirectal nodes are most frequently neoplastic and imply occult regional metastasis.

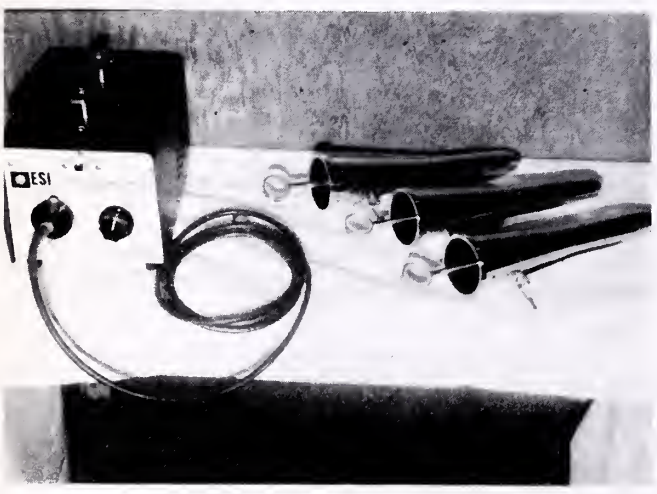


Fig. 3. — The Sischy treatment sigmoidoscope system[7] for endorectal irradiation.

Results • Papillon's most recent report,[2] with 280 patients treated radically, has a 5-year disease-free survival of 73.9% with only 11 patients (5.3%) failing in the primary site. Eight were successfully salvaged by surgery. Of 146 patients followed for ten years, there is a 58% disease-free survival with no local recurrences after the fifth year; 29.4% died of intercurrent disease, only 10% of cancer. Similarly, Sischy reports a 94% recurrence-free survival with a median follow-up period of 18 months in 94 cases;[3] Basrur's patients achieved an 87% disease-free survival.[4]

These control rates equal or exceed those for fulguration or cryosurgery and rival those reported for optimal local excision or radical surgery for stages A-B_1. They surpass the best results of definitive external beam radiation.[5]

Endorectal irradiation also palliates discharge, bleeding, and pelvic pain from sites within reach of the treatment proctoscope in 80% of patients beyond cure, without significant morbidity even when maximal external irradiation had been given.[3] It is also a valuable adjuvant post-polypectomy for control of large recurrent villous adenomas of borderline histology.[2,3]

Eight patients have been treated radically in the first year of our endorectal irradiation program, all over age 70 and medically inoperable. Three patients were treated after failure of other conservative modalities. All lesions were mobile, exophytic, and well- or moderately-differentiated. Other than transient hypotension related to premedication in two cases, tolerance to therapy was excellent. Seven lesions regressed completely by the fourth fraction. Seven patients were rendered locally disease-free; one failed locally and was salvaged at eight months. One patient treated for recurrence in a defunctioned rectal stump developed hepatic metastases at nine months and subsequently died. A ninth patient with an anastomotic recurrence low in the rectum and coexisting liver metastases was treated palliatively; because of the bulk of tumor, only partial control was achieved but an abdominoperineal resection was avoided.

Treatment techniques • Routine pretreatment evaluation by the radiation oncologist includes sigmoidoscopy, liver function studes and CEA determinations. A double-contrast barium enema is performed and pelvic CT scan to assess both lesion thickness and possible occult spread.

Patients are prepared with either polyethylene glycol-electrolyte osmotic lavage or enemas. Meperidine and intravenous diazepam are given in the outpatient holding area, and the patient is placed on a sigmoidoscopy table in jackknife position. After a rigid sigmoidoscopy to locate the lesion and assess response, the rectum is progressively dilated to 4 cm using either topical anesthesia with xylocaine viscous or additional diazepam. The applicator is held firmly in place against the lesion under direct vision; the tip of the x-ray tube is docked into the applicator and treatment is given over 2-3 minutes for 2000-3500 cGy.

Radiation safety precautions are those required for diagnostic x-ray units. Regular lead aprons and gloves are used by the radiation oncologist and technologist and the metal applicator defines the beam to protect normal surrounding tissues.[7]

Rectal discomfort or discharge and occasional hematochezia can occur between treatments. These respond well to conservative measures such as topical steroids. The treated rectal wall ultimately becomes fibrotic with telangiectasia and atrophy of the mucosal surface. Our patients are encouraged to use stool softeners and maintain a high-fiber diet to prevent the rare occurrence of intermittent bleeding after straining. Because of fibrosis and atrophy, a biopsy site may ulcerate; areas suspicious of recurrence should be biopsied with caution. A superficial cytologic specimen may suffice to document recurrence. Apart from direct sigmoidoscopic follow-up at 8-12 week intervals, CEA, barium enemas, and colonoscopy are performed at appropriate intervals.

Acknowledgements

We express our gratitude to the Albert and Birdie Einstein Foundation for its generous ongoing support of our program in endorectal irradiation. Drs. V.R. Basrur and P. McKnight, Ontario Cancer Foundation, Hamilton, Ontario, Canada, graciously allowed us to use Figures 1(a-e) from their clinical collection.

References

1. State of Florida, Department of Health and Rehabilitative Services, "Cancer In Florida — 1981", Tallahassee, 1985, pp. 25-28.
2. Papillon, J.: Rectal and Anal Cancers; Springer-Verlag, Berlin, 1982, pp. 3-105.
3. Sischy, B.; Graney, M.J., and Hinson, E.J.: Endocavitary Irradiation for Adenocarcinoma of Rectum, CA 34:333-339, 1984.
4. Basrur, V.R. and Knight, P.R.: Intracavity Radiation for Rectal Carcinoma, J. Can. Assoc. Radiol. 34: 43-46, 1983.
5. Cummings, B.J.; Rider, W.D.; Harwood, A.R.; Keane, T.J., and Thomas, G.M.: Radical External Beam Radiation Therapy for Adenocarcinoma of Rectum, Dis. Colon Rectum 26: 30-36, 1983.
6. Cohen, A.M.; Gunderson, L.L., and Welch, C.E.: Selective Use of Adjuvant Radiation Therapy in Resectable Colorectal Adenocarcinoma, Dis. Colon Rectum 24: 247-251, 1981.
7. Bramlet, R.; Tobochnik, N., and Sischy, B.; Endocavitary Contact X-Ray Applicator System for Treatment of Rectal Carcinoma, Brit. J. Radiol. 58: 147-149, 1985.
8. Gunderson, L.L. and Sosin, H.: Areas of Failure Found at Reoperation (Second or Symptomatic Look) Following "Curative Surgery" for Adenocarcinoma of Rectum, Cancer 34: 1278-1292, 1974.
9. Morson, B.C.: Factors Influencing Prognosis of Early Cancer of Rectum, Proc. Roy Soc. Med. 59: 607-608, 1966.

- Dr. Tepperman, 3501 Johnson Street, Hollywood 33021.

Technetium 99m MDP uptake in drug-induced fibrous myopathy

Bruce A. Rodan, M.D., William J. Bean, M.D., and David Mullin, M.D.

ABSTRACT: Bone scanning agents are known to accumulate within various nonosseous structures. We present a case of soft tissue uptake of Technetium 99m MDP in a drug abuser. Chronic intramuscular injections of pentazocine and meperidine led to muscular fibrosis with dystrophic calcification. The clinical features of pentazocine-induced fibrous myopathy are presented.

The Authors
BRUCE A. RODAN, M.D.
WILLIAM J. BEAN, M.D.
DAVID MULLIN, M.D.
Drs. Rodan, Bean and Mullin are Staff Radiologists at the Palm Beach-Martin County Medical Center, Jupiter.

Bone scanning agents are known to accumulate within various nonosseous structures. Soft tissue changes may be manifest on radionuclide bone scans. Increasing drug abuse has led to a heightened awareness of certain rheumatic complications. We present a case of soft tissue uptake of Technetium 99m MDP in a patient with pentazocine and meperidine-induced fibrous myopathy.

Case Report • A 43-year-old white married female was evaluated for a chronic pain disorder. Historically her complaints were of 14 years' duration when a nephrotic syndrome developed. A renal biopsy was consistent with healed immune complex glomerulonephritis, membranous type. A diagnosis of relapsing polychondritis was obtained from a left ear cartilage biopsy. She was treated with cortisone and immunosuppressive drugs. Subsequent complications of this therapy included peptic ulcer disease, aseptic necrosis of the right hip requiring a prosthetic implant, and a lumbar compression fracture.

The onset of the pain disorder was reportedly coincidental with numerous major stress-provoking life events. The pain was described as a dull ache mostly experienced in the nose and ears as well as in the arms and low back. The major complaints were mostly psychological, such as sleep disorder, self-destructive thoughts and preoccupation, and massive weight gain. She also suffered from chronic hypochondriasis with multiple substance use disorder. The patient stated she was on pentazocine (Talwin) 10-15 cc IM daily and meperidine (Demerol) up to 400 mg IM daily prior to evaluation.

The most striking findings on physical examination were areas of induraton involving the deltoid, gluteal and quadriceps muscles. These corresponded to sites of self-administered intramuscular injections. No cutaneous abnormalities or neurologic changes were present.

A radionuclide bone scan (Fig. 1A,B) was performed following the injection of 20 millicuries of Technetium 99m MDP. This revealed areas of diffuse, symmetrical uptake in the soft tisues of the arms, buttocks and thighs. Radiographs of these areas revealed a few scattered fine calcifications within the soft tissues. No bony lesions were seen. The

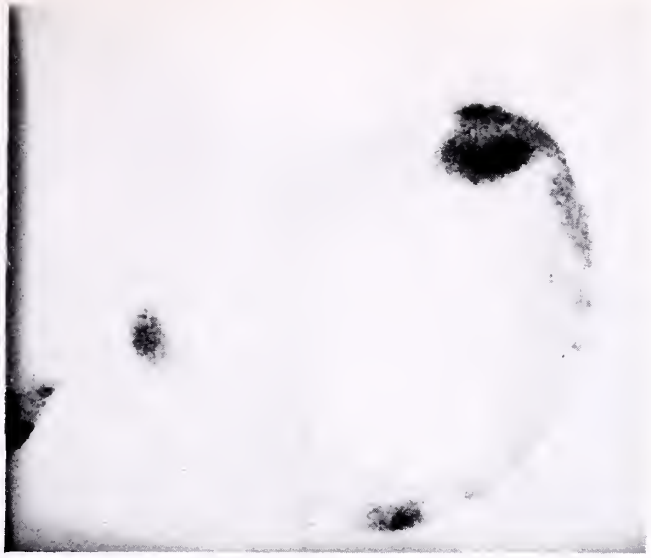


Fig. 1A. — 99m Technetium MDP scan of right upper extremity reveals soft tissue uptake in the deltoid muscle. Similar uptake was present in the left arm.

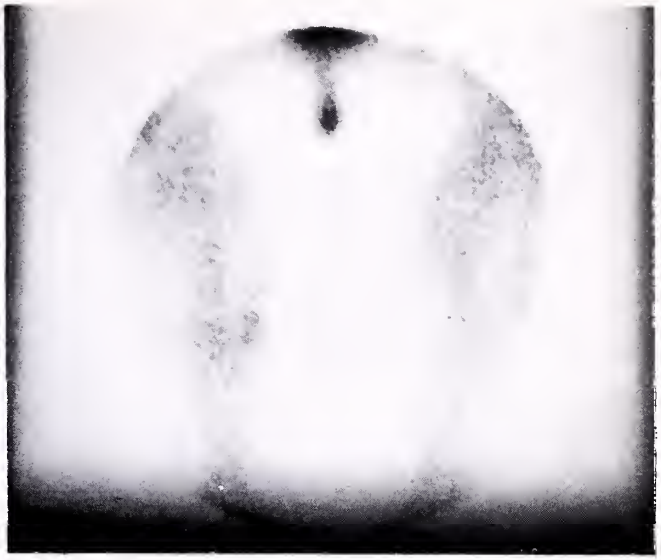


Fig. 1B. — Scan of both thighs reveals soft tissue uptake in both quadriceps muscles. These corresponded to areas of induration from intramuscular drug injections.

radiopharmaceutical uptake directly corresponded to the sites of induration, a fibromyositis caused by chronic pentazocine and meperidine injections.

Discussion • Bone scanning agents are known to concentrate in various nonosseous structures.[1-3] The mechanism of action is uncertain. Whether persistent accumulation or exchange with calcium in abnormal tissue or some other alteration of soft tissue is responsible for Technetium uptake in dystrophic calcification is not known.[4] Technetium 99m MDP accumulates in areas of bone accretion; however, with dystrophic calcification there are no associated osteoblasts and the mechanism may be different. Some derangement of calcium and phosphate metabolism is a common finding in extraosseous uptake.[1] Technetium agents can localize in soft tissue lesions which have an active transport of calcium and/or phosphate.[5] Radioisotope techniques are more sensitive than radiographs for the detection of bone abnormalities and this might be true for some soft tissue diseases which produce extraskeletal ossification.

The mechanisms by which chronic intramuscular injections lead to muscle fibrosis are not completely understood. Although it is hypothesized that pentazocine,[6,7] and meperidine[8,9] may be the offending agents, repeated needle trauma in itself may explain the process. Chronic focal infection or chemical irritation by the drugs themselves may establish chronic inflammation which stimulates fibroblast proliferation.[10]

In pentazocine-induced fibrous myopathy, muscle biopsy shows extensive fibrosis of the skin and muscle with scattered collections of lymphocytes, frequently around vessels, areas of calcification and focal areas of atrophied muscle fibers.[7] The most characteristic finding is fibrotic induration in the quadriceps and deltoid muscles, the common sites of injection. There is considerable limitation of motion due to fibrotic muscle contracture; however, only minimal weakness of involved muscles is noted. Distinctive cutaneous features, which are not found in all patients, include (1) the tense, woody, expansive fibrosis that extends well beyond the sites of injections, (2) the irregularly shaped deep ulcers, often deep enough to expose the muscle, (3) a halo of pigmentation around the ulcers, and (4) a distinctive lack of pain despite the indolent process.[11]

Extraosseous localizations of Technetium bone scanning agents are commonly encountered. Normal physiologic sites include the kidneys and cartilage. Common artifacts are free pertechnetate in the thyroid or stomach, activity at the injection site or due to urine contamination. Areas of dystrophic calcification may also be encountered in tissue injury, degeneration or necrosis. This is increasingly seen in intramuscular narcotic drug abuse, illustrated by our case of pentazocine and meperidine-induced fibrous myopathy.

References

1. Desai, A.; Eymontt, M.; Alavi, A., et al: 99m Tc-MDP Uptake in Non-osseous Lesions, Radiol. 135:181-184, 1980.
2. Heck, L.L.: Extra-osseous Localization of Phosphate Bone Agents, Semin. Nucl. Med. 10:311-313, 1980.
3. Spencer, R.D., and Datu, J.A.: Bilateral Lower Limb Uptake of Bone Scanning Agents, Semin. Nucl. Med. 10:314-316, 1980.
4. Epstein, D.A.; Solar, M., and Levin, E.J.: Demonstration of Longstanding Metastatic Soft Tissue Calcification by 99m Tc diphosphonate, Am. J. Roetngenol. 128:145-147, 1977.
5. Suzuki, Y.; Hisada, K., and Takeda, M.: Demonstration of Myositis Ossificans by 99m Tc Pyrophosphate Bone Scanning, Radiol. 111:663-664, 1974.
6. Steiner, J.C.; Winkelman, A.C., and de Jesus, P.V.: Pentazocine-Induced myopathy, Arc. Neurol. 28:408-409, 1973.

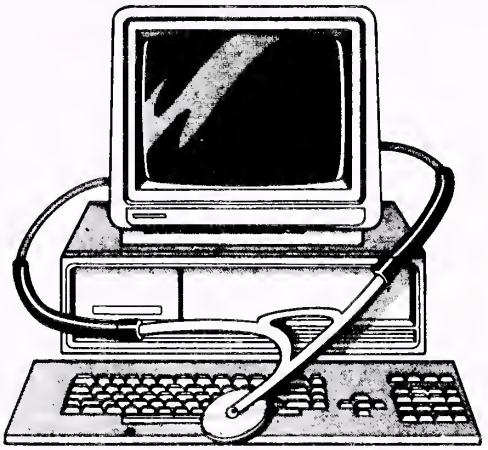
7. Oh, S.J.; Rollins, J.L., and Lewis, I.: Pentazocine-Induced Fibrous Myopathy, JAMA 231:271-273, 1975.
8. Aberfeld, D.C.; Bienenstock, H.; Shapiro, M.S., et al: Diffuse Myopathy Related to Meperidine Addiction in Mother and Daughter, Arch. Neurol. 19:384-388, 1968.
9. Mastaglia, F.L.; Gardner-Medwin, D., and Hudgson, P.: Muscle Fibrosis and Contractures in Pethidine Addict, Br. Med. J. 4:532-533, 1971.
10. Johnson, K.R.; Hseuh, W.A.; Glusman, S.M., et al: Fibrous Myopathy, Rheumatic Complication of Drug Abuse, Arth. Rheum. 19:923-926, 1976.
11. Parks, D.L.; Perry, H.O., and Muller, S.A.: Cutaneous Complications of Pentazocine Injections, Arch. Derm. 104:231-235, 1971.

● Dr. Rodan, 1210 South Old Dixie Highway, Jupiter 33458.

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Office Skills
WORKSHOPS
for the Primary Care Physician

February 26-28, 1986

FLORIDA HOSPITAL MEDICAL CENTER

Radisson Plaza Hotel

Orlando, Florida

WORKSHOPS OFFERED:

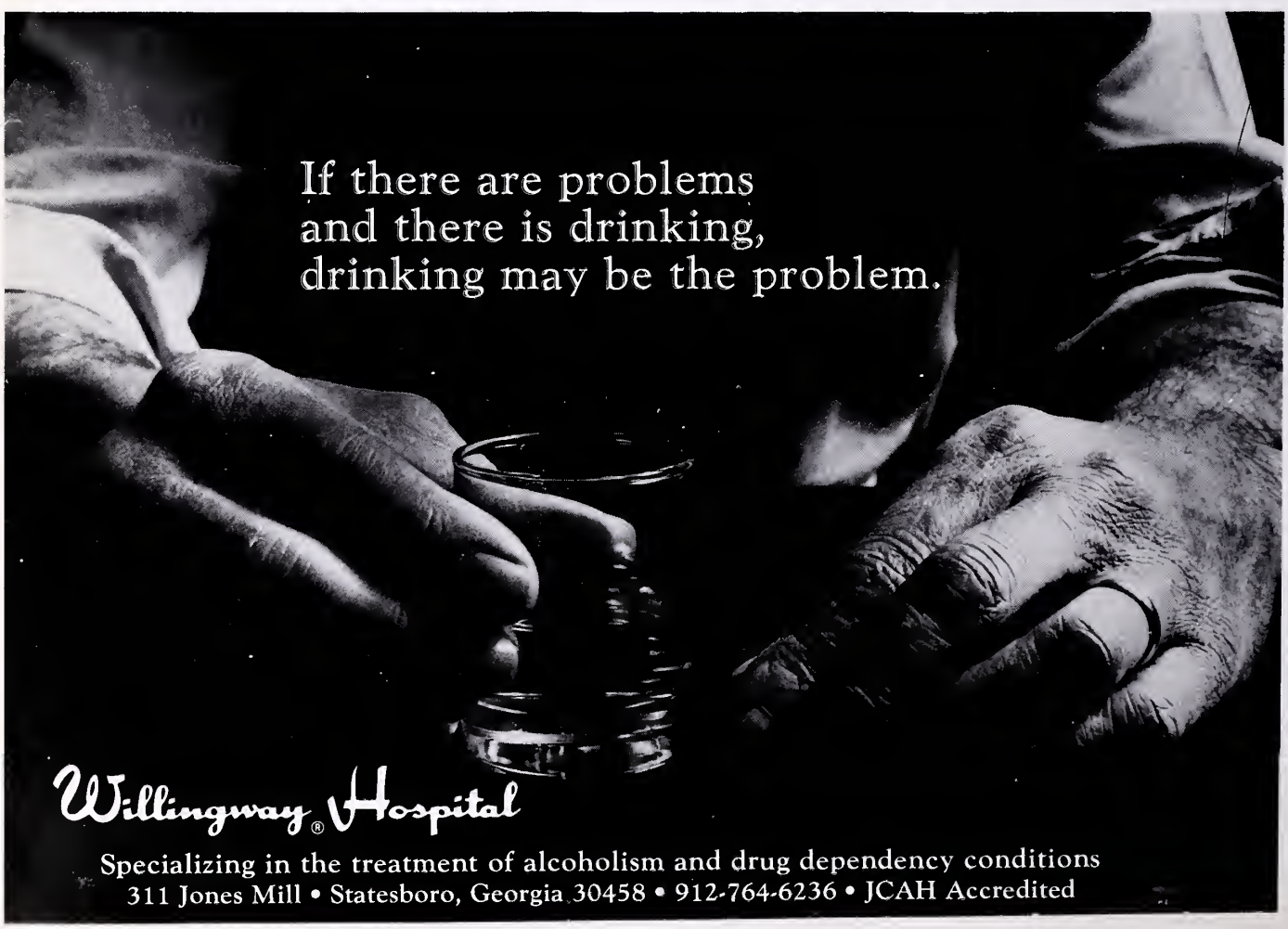
- Flexible Sigmoidoscope
- Cardiac Stress Testing and Holter Monitoring
- Joint Injections and Aspiration Techniques
- Electro-cautery
- Fiberoptic Laryngoscopy
- Cryo-surgery
- Office Audiometry
- Office Pulmonary Function Testing

TUITION:
Physicians — $325
Residents — $190

Sponsored in conjunction with University of South Florida College of Medicine

FMA approved for 20 hours of Category I credit

For more information, please contact:
Orris Rollie, M.D. (305) 897-1514
or Lucinda Galusha



The academic medical center as an endangered species

The financial viability of medical academic institutions is being threatened. The decrease in inpatient hospital census, the limited funds available for caring for the more severely ill imposed by DRGs, and the proposed cutbacks of subsidies for medical education by government and private insurance companies may severely disrupt the structure of our medical centers.[1]

Many practicing physicians will approach the plight of the academic centers with avid apathy; after all, they feel burdened with their own difficulties such as problems with Medicare reimbursement, encroachment on their own patient numbers by HMOs and PPOs, and the myriad other harassments associated with private practice. Lack of concern for our medical centers is inappropriate. Let us not forget that the academic centers birthed, nourished, protected, and even supported some of us during our professional infancy. Let us not forget that most of the procedures we perform, the specialized skills we have obtained, and the scientific knowledge that sustains us in our practice have emanated from teaching institutions. The strangulation of medical academe will foster the professional stagnation and decay of the practitioner. Organized medicine must provide political, moral, and economic support of our teaching institutions.

Medical centers have burgeoned in size and number during the past half century. They have evolved from depression-vintage institutions that primarily cared for large numbers of indigent patients, that were served by a large voluntary staff and a few full-time faculty, and in which clinical research was performed on a part-time basis by a select few investigators. They have evolved into institutions that compete with all other hospitals for patients from all strata of society. Their faculties are usually full time and number in the hundreds. The research budgets of the large centers mount into the tens of millions of dollars. The number of medical schools has increased from 86 to 127 in the last fifteen years and their student enrollment has swelled from 21,000 in 1960-61 to 67,000 in 1984-85. This evolutionary growth resulted from the serial input and convergence of several programs that were introduced after World War II. In 1945 and 1946, the Veteran's Administration Hospitals forged links with academic health centers. This action provided care for veterans and support for residency training. In the 1950's, Congress opened the financial spigots to promote biomedical research. In the 1950's and 1960's, hospital insurance was extended to the majority of families of employed individuals and this provided monies for patient care. State support of new medical schools provided resources for capital and operating expenses in the 1960's and 1970's. At the same time, the Medicare and Medicaid programs were introduced. These provided additional funding for elderly and indigent care and secondarily for medical education. Finally, in 1971, capitation grants were legislated for the training of additional medical and other health professional students.

The blizzard of new monies that has fallen upon the academic centers in the past forty years has created an academic health care system unsurpassed anywhere in the world. However, this evolution has also produced a predicted surplus of 70,000 physicians by 1990 and 145,000 physicians by the year 2,000. This surfeit of physicians has received some of the blame for the escalation in health care costs in

the 1970's and 1980's. The surplus has also encouraged government and private health care payers to decree that they will no longer reimburse academic medical centers for that portion of medical care charges that can be attributed to medical education. Since patient care income now provides the largest single source of funding for academic health centers (about one-third of their budgets) a significant reduction in patient care reimbursement will certainly upset the fragile financial stability of most centers.

Teaching institutions are lumbering behemoths that are especially vulnerable to the present salvos of economic mutation. Individual practitioners, whole group practices, large clinics, and even private hospitals can respond to economic and demographic change by relocating or by rapidly altering their administrative or financial structures. Teaching institutions lack these elastic adaptive mechanisms because they are so different. The complexity of their mission is different, i.e., they have teaching and research functions to perform in addition to their patient care responsibilities. Their financing is different, i.e., they are pathetically dependent on federal and state governments for their survival. Their governance is different; it is encrusted by burdensome regulations imposed by granting agencies and state governments that severely stifle the managerial innovation necessary for survival in today's harsh economic environment.

Teaching centers may suffer greatly but they will not succumb to a dinosaur-like extinction. They have always survived crises before. Inner cities have thrived, decayed, and revived again as have political and sociologic trends. Through all of this, the great teaching institutions have endured as sphinx-like edifices that watch over the human bustle about them. Their buildings may have been given external facelifts and internal amputations and transplantations. Dilapidated structures have been torn down and new ones erected but the spirit of the institutions has remained intact. Energized by the continual ingress and efflux of countless bright and highly motivated minds, they have percolated with an exhilarating rhythm that has invigorated all of medicine. This cadence may be temporarily asynchronous with today's political and economic pulsations. However, the great centers will prevail through this current difficulty. Hopefully, they will not be so injured that it will require decades for their recuperation. We need to recognize these unique difficulties being experienced by our teaching institutions.

For this reason, I have asked Dr. Knapp and Dr. Bentley to write the appended paper "Understanding the Challenge Facing Teaching Hospitals." Dr. Knapp is Director and Dr. Bentley Associate Director of the Department of Teaching Hospitals of the Association of American Medical Colleges.

References

1. Ginzberg, E.: Academic Health Centers Troubled Future Health Affairs (Summer 1985) 5-21.
2. Relman, A.: Who Will Pay For Medical Education In Our Teaching Hospitals? Science Vol. 226; 220-223, 1984.

Jacques R. Caldwell, M.D.
Daytona Beach

Understanding the challenge facing teaching hospitals

Contemporary American teaching hospitals are among our nation's most complex enterprises. They combine many of the characteristics of community general hospitals, specialty referral centers, social service and welfare agencies, educational institutions, and research institutes. These characteristics are combined in many different ways in individual teaching hospitals depending upon the hospital's mission, its role in the community, the resources available to it, its past history, and its view of the future. The characteristics also vary with the hospital's relationship to the medical school. Depending on the definition used, the number of hospitals classified as teaching hospitals varies dramatically. For example there are only sixty-one hospitals under common ownership with a college of medicine. There are an additional fifty to sixty hospitals where the majority of medical school department chairmen also serve as the hospital chief of service. Four hundred and thirty hospitals belong to the Council of Teaching Hospitals of the Association of American Medical Colleges (AAMC). An estimated 1,100 hospitals have some type of affiliation with a medical school, and about 1,350 hospitals participate in at least one residency program.[1]

However, it is not difficult to characterize the financial environment and risks facing teaching hospitals. The financial environment for hospitals has changed dramatically in the past five years. While hospitals once competed primarily on the breadth of their missions and the scope of services provided to support practicing physicians, they now compete increasingly on the basis of price.

Many health care payers are currently experimenting with a variety of approaches that will allow them to spend their health care dollars "more wisely." These payers have attempted to find out precisely what they are being charged and to restrict themselves to paying for only those goods and services they believe are necessary and reasonable for the care of their patients. They then negotiate the most favorable price they can for those goods and services.

Some payers have defined the services they will buy as those necessary for the total health of their insured population, and they have developed or entered into a capitated arrangement, frequently a health maintenance organization (HMO). Others have retained the more traditional fee for service model, but they have sought to change how those services are purchased by setting prices or engaging in competitive arrangements to encourage efficient, low cost delivery of services. The best known arrangements to set prices for services delivered is Medicare's Prospective Payment System which redefines the unit of service delivered as all hospital care rendered to a patient during a hospital admission and pays a fixed price based on the patient's diagnosis. Other fixed price arrangements have been established by law or negotiated by large insurors to pay for hospital care on a per case or patient day basis. In other instances, large scale purchasers of health services have been able to create preferred provider arrangements to achieve price discounts from hospitals.

"Cost shifting" is a term that has been used to describe the circumstances when a patient is provided services, and the cost of caring for that patient is met through increased charges to other patients. The term cost shifting has been used primarily in discussions of uncompensated care. However, there are other types of cost shifting that do occur in hospital financial arrangements. They are more commonly referred to as cross subsidies, but the principle is the same.

Price competition threatens teaching hospitals because they historically have supported, or cross-subsidized, four special services with patient care revenues from routine patients. The subsidized services and/or products have included: (1) clinical education in the health sciences; (2) clinical research and applied technology; (3) regional standby and tertiary services; and (4) uncompensated care.

As price competition requires teaching hospitals to reduce charges for routine services to paying patients it is unclear how the costs of these special services will be supported in the future. In this circumstance, it is important to understand the special services of teaching hospitals and the added costs of offering these services.

Clinical education • Teaching hospitals are major educational institutions. In 1985, teaching hospitals provided the training sites for over 80,000 residents and fellows in graduate medical education programs, over 30,000 students in the last two years of medical school, and large numbers of nurses and allied health professionals. The clinical education of medical, nursing and allied health students is organized around the daily operations of the hospital. Patients are being treated and students are being trained through the same activities. In effect, both products — patient care and education — are being simultaneously, or jointly, produced. The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs — education is not simply a byproduct. The addition of the educational role does involve additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. It is most difficult, however, to identify distinctly many of the educational costs because of the impossibility of a clear separation of clinical care and clinical education.[2] It is also difficult to quantify the service benefits teaching hospitals receive from physicians, nurses, and allied health professionals in training programs.

Residents learn clinical skills through supervised participation in the diagnosis and care of patients. The patient service benefits that accompany this learning reduce, in some part, the costs of graduate medical education programs. The cost reduction varies with the patient's clinical needs and the resident's level of training. Service benefits provided by residents are probably more substantial for tertiary care patients requiring continuous medical supervision than for routine patients and are greater for senior residents than junior residents. While there is no conclusive study comparing the costs added by residency programs with the service benefits provided by residents, hospital executives and medical educators generally believe that the costs of operating a residency program exceed the service benefit obtained by patients. This added cost is the investment necessary to adequately prepare the future generation of professional health personnel.

Clinical research and applied technology • In the past four decades, the medical sciences have made dramatic advances in diagnosis and treatment. Much that is now widely available was unknown a generation or two ago. Many of these advances began in the basic reasearch laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals.

The reputation of teaching hospitals for state-of-the-art medical care is world-renowned but difficult to quantify. Hospital industry surveys generally do not inquire about new, rare or unique services. Occasionally, a national inventory does provide some insight. For example, in 1980, the U.S. Public Health Service published a list of clinical genetic service centers. Of the 223 listed centers, 82 were hospital programs with 57 of these (70%) sponsored by members of the Council of Teaching Hospitals. An additional 36 programs were located in state

agencies, private health agencies, and private research institutes. The largest concentration, 105 programs, was located in universities, but in these university programs, the roles of their teaching hospitals were not separately identified.

The clinical genetics data illustrates the problem of identifying the teaching hospital's role in clinical research. In many cases, the university's faculty are also the hospital's medical staff. The specific identification of research program location may reflect more upon the flow of grant funds (e.g., National Institutes of Health to university) than on the actual site of the research (i.e., university of hospital). Data on clinical research derived from funding flow typically understates the teaching hospital's role.

The hospital's role is also understated in published research. While the investigator may be conducting his or her research activities in the hospital using its laboratories and studying its patients, citations in the publication of a research article often relate more to academic advancement than to enhancing prestige in patient care. As a result, authors of clinical studies performed in the hospital generally list the university where they have faculty rank rather than the hospital where they have admitting privileges.

The presence of medical research in the teaching hospital has environmental, managerial, and financial implications. To attract and retain research-oriented faculty physicians, the hospital must create and maintain a climate conducive to research: research scholarship must be esteemed, research support and supplies must be readily available, and individual hospital departments must be flexible and responsive to the demands accompanying research. Managerially, the inclusion of medical research in a teaching hospital's primary mission requires governing board and senior management commitment to integrating research into the daily operations of the hospital: specialized supporting staff must be hired and trained, necessary research review and patient protection procedures must be developed and monitored, record-keeping and reporting required by the funding organization must be established, and management styles appropriate for personalized and efficient patient care must be balanced with a collegial style appropriate for research productivity.

Establishing a medical research program increases a teaching hospital's costs. Additional costs are incurred for staff, supplies and equipment, space, maintenance and upkeep, and record-keeping. Most but not all of these added costs are supported by grants, contracts, endowments, and gifts. Regular hospital services provided for research patients are generally paid by the patient or his third party coverage. However, the definition of routine care for patients on research protocols is an issue which requires discussion. Many elements confound the ability to conduct an acceptable study to determine the extent to which services provided according to a research protocol cost more than care for the same diagnosis in the absence of a research protocol.[3] Points that need to be considered are as follows:

(1) The difficulty of isolating procedures and therapies ordered and performed under research protocols from those that could occur under a routine or standard regimen, and identifying their specific costs.

(2) Identifying clinical trial patients and a matched control group for comparative purposes presents dilemmas. In many diseases for which research is conducted there exists no generally accepted treatment.

(3) Clinical trials vary in complexity, from testing the dosage and administration of drugs to the use of new technologies, therapies or invasive procedures.

(4) Involvement in clinical trials may be related to consideration of the complexity of stage of illness. In other words, research participation may be focused on the sicker patients. This would establish a further degree of difficulty in isolating research-related costs, due to the lack of agreement as to how severity measures can be imposed as evaluative criteria.

(5) Care must be given to agreement on the time frame acceptable for comparison of research and non-research related costs of care. Clinical trial paritication may be of short duration, extend over several years, require inpatient or outpatient follow-up, or extended or shortened nursing time due to drug administration.

There is much about this subject which is not well understood. However, without an appropriate environment as well as managerial and financial support, clinical research will not flourish.

Regional standby and tertiary care services • The teaching hospital's patient care reputation is clear; it is the place for the most severely ill patients. Teaching hospitals are the primary source of microsurgery, joint replacement surgery, transplant surgery, specialized laboratory and blood banking services, and specialized neurological and opthalmologic procedures, to name a few. Patients with the most severe medical needs tend to be sent to teaching hospitals for the latest care capabilities.

While the charges for many teaching hospital services are related to the costs of providing them, there are some services for which special charges are not made, or charges are not set high enough to cover full costs. For example, at many medical center hospitals, services are provided to a very substantial number of high risk pregnant women. The cost of providing services to these women is substantially higher than the cost of providing ser-

vice to a woman whose pregnancy is without substantial risk. In most hospitals the charges for services to these two groups of women are substantially the same. However, the costs of providing these services are quite different. In effect, the patient with extensive needs is being subsidized by the patient with routine needs since the charges and costs are based on "averages." In a market where patients are sensitive to hospital prices, the teaching hospital is therefore at a disadvantage.

To survive in the evolving medical marketplace, teaching hospitals will lower their prices for routine services and will begin to price services for standby services and other tertiary care services at a rate which is related more clearly to the cost of providing such services. Thus, the public will have to become used to paying much higher prices for these services, and the price of these services may rise rather dramatically in the short run.

Uncompensated care • Because of the long and distinguished history of hospitals such as Jackson Memorial Hospital in Miami, Bellevue Hospital Center in New York City, and Cook County Hospital in Chicago, many individuals perceive the non-Federal members of the AAMC's Council of Teaching Hospitals (COTH) as "charity care teaching hospitals." Charity care and medical education are assumed by some to be necessarily interdependent objectives of major medical centers. There is some validity to this perception. First, in 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of its admissions, incurred 35% of the bed debts and 47% of the charity care. Secondly, many municipally-sponsored "charity" hospitals historically have had difficulty recruiting an adequate number of physicians. To provide appropriate and necessary medical services to their patients, those hospitals have often affiliated with local medical schools to obtain the professional medical services which are provided by residents training under faculty supervision. These affiliation arrangements have benefitted both the patients receiving care and the physicians receiving supervised training. Thirdly, when states and municipalities have authorized appropriated funds to help finance hospitals with disproportionate charity care populations, the funding has sometimes been given an educational label to either increase its political acceptability or to channel it to particular hospitals. These three relationships between teaching hospitals and charity care have left many in our nation with the stereotypical view that the terms "teaching hospitals" and "charity care hospital" are synonymous.

This perception is not completely accurate, and its perpetuation can hamper appropriate discussions of the options for addressing uncompensated care. It should be noted that the uncompensated care burden of teaching hospitals is bimodal: some teaching hospitals, both publicly owned and not-for-profit, provide vast amounts of uncompensated care but many provide an amount comparable to non-teaching, non-profit hospitals. Secondly, it must be recognized that medical students and residents can be trained without charity care patients. Therefore, if the issue of uncompensated care is to receive the attention it deserves, the issues of uncompensated care and medical education need to be separated.

There are at least seven primary concentrations of uncompensated care: (1) obstetrical and pediatric patients; (2) chronically ill patients repeatedly admitted; (3) patients awaiting placement in a less than acute care setting; (4) patients admitted for catastrophic medical services such as burn or trauma care; (5) uninsured patients including the unemployed and illegal aliens; (6) patients who have abused drugs and alcohol; and (7) insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially.

Many teaching hospitals have provided care for economically disadvantaged patients for decades. Prior to Medicare and Medicaid, much of that care was organized into charity clinics and housestaff wards. Since 1965 and the national commitment to "mainstreaming" indigent patients, teaching hospitals have made substantial strides toward replacing two classes of care with a single class of care.

Some teaching hospitals have provided a community-based "safety-net" for the medical needs of the poor and medically indigent by offering extensive ambulatory and emergency services. Teaching hospitals have been able to do this because some were assisted with tax revenues and some were assisted with philanthropy, but most subsidized uncompensated care through higher charges to charge paying patients.

Conclusion • Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on price competition places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If developing policies on health care delivery and payment recognize and support financially and distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic policies may damage the ability of these institutions to fulfill their multiple responsibilities.

References

1. Liason Committee on Graduate Medical Education, Directory of Accredited Residencies, 1985-86, Chicago.
2. Medical Education Costs in Teaching Hospitals: An Annotated Bibliography, Association of American Medical Colleges, April, 1985.
3. Karen Pfordresher, "Clinical Research and Prospective Payment," COTH Report, January 1985.

James D. Bentley, Ph.D.
Associate Director
Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Association of American Medical Colleges

Medicine
and
The Law

Management of the Risk of Malpractice Allegations

A Medical Seminar on Risk Management

January 3-4, 1986

to be held at

The Medical Center Auditorium
College of Medicine
Univerity of South Florida
Tampa, Florida

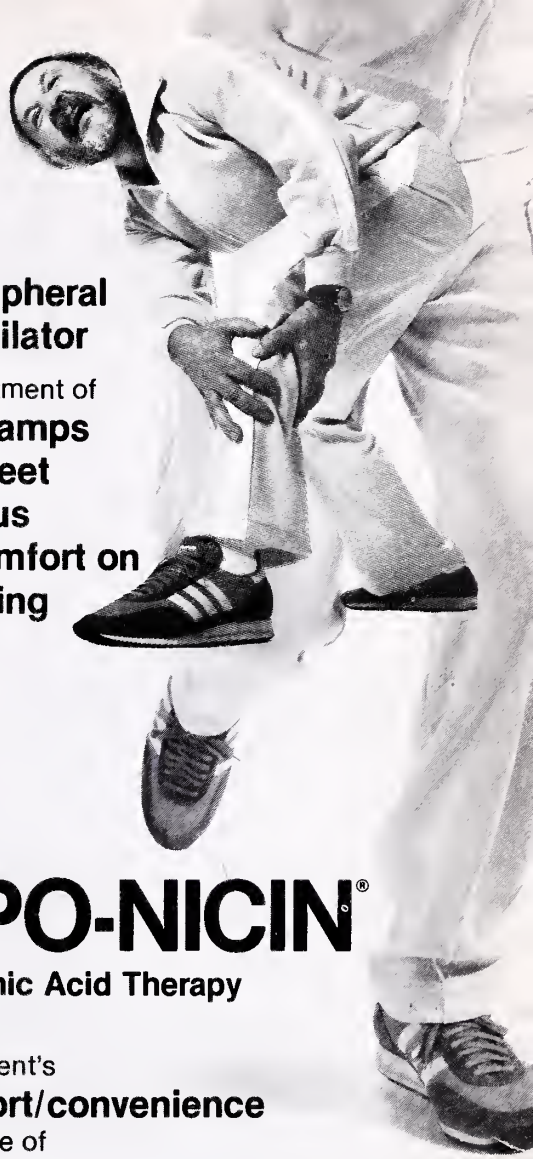
Co-sponsored by The College of Medicine, University of South Florida, and The American College of Legal Medicine.

- Pre-Trial Seminar
- Mock Trial
- 14 hours Category I credit
- Acceptable for credit in Risk Management

For further information, please contact:

Office of Continuing Medical Education
12901 N. 30th Street
University of South Florida
Tampa, Florida 33612

(813) 974-4296



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

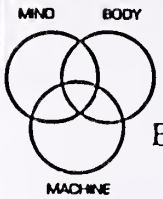
Send the bill for $15.00 (add .75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____

BIOFEEDBACK



DOCTORS:
Would you like
Biofeedback Therapy
in YOUR office???

We can provide:
CERTIFIED THERAPISTS
INSTRUMENTS
COMPLETE INITIAL SET-UP
ONGOING CLINICAL SUPERVISION

Call or write for details:
BIOFEEDBACK INSTITUTE
2429 UNIVERSITY BOULEVARD, W.
JACKSONVILLE, FLORIDA 32217
(904) 737-5821

LAKE BUTLER HOSPITAL
HAND SURGERY CENTER

The Southeast's Specialized Surgery Center For:

- Injuries and Deformities of Hands and Feet
- Plastic and Cosmetic Surgery
- Reconstructive Microsurgery
- Comprehensive Hand Therapy

(904) 496-2323
24-HOUR EMERGENCY

850 E. Main Street • Lake Butler, Florida

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 1055
- ☐ ENCORES!, 1056
- ☐ SCAM OF THE MONTH, 1061
- ☐ CORRECTION, 1061

NOTES & NEWS

Palm Beach County Chapter of Heart Association funds new Schiebler Chair in Pediatric Cardiology

A $600,000 donation from the Palm Beach County Chapter of the American Heart Association (AHA) will fund the establishment of an Eminent Scholar's Chair in pediatric cardiology at the University of Florida.

Representatives of the chapter presented the gift on November 8 to UF President Marshall Criser and Dr. William B. Deal, dean of the College of Medicine, during a press conference at the chapter headquarters in West Palm Beach.

Honored during the program was UF administrator and pediatric cardiologist Dr. Gerold L. Schiebler, for whom the endowed chair is being named. Dr. Schiebler recently assumed a new administrative position as associate vice president for health affairs for external relations at the UF Health Science Center. He is in his 25th year with the UF pediatric faculty and has served 17 years as chairman of the Department of Pediatrics. He also has become known as "the children's friend in the Florida Legislature" after attending more than 10 legislative sessions in Tallahassee to lobby support for children's health programs.

Joseph B. Shearouse Jr., president of Fidelity Federal Savings Bank in West Palm Beach and chairman of AHA's local Eminent Scholar Chair Committee, said, "Establishing a teaching chair in Dr. Schiebler's honor is a great opportunity for the Palm Beach County Chapter to continue contributing to the advancement of cardiac care. Endowing the chair is a high point for this chapter, now in its 34th year."

In addition to the Schiebler Chair, the chapter also contributed $600,000 in 1984 for an Eminent Scholar's Chair in adult cardiology. . .a position for which more than 60 scientists have been nominated. Outstanding candidates are now being selected for interviews at UF.

Schiebler was cited during the presentation ceremony for his numerous contributions to significant improvement of Florida medical services for infants, children and their families. He has worked with Florida pediatricians and state government to bring about legislation that resulted in development of a statewide program for children with rheumatic heart disease, and a statewide network of neonatal and perinatal intensive care units; as well as regional screening programs for infant hearing problems, curvature of the spine, kidney disease, genetic abnormalities, and metabolic disorders.

A more recent result of his lobbying effort was the establishment of the Child Protection Teams now serving the entire state through the Department of Health and Rehabilitative Services (HRS).

Schiebler has been an active volunteer supporter of the American Heart Association for 21 years, and in 1979, he won the association's highest award. . . the Distinguished Service Medallion.

His contributions to pediatric cardiology include establishing the nation's first training program (at Shands Hospital) for cardiovascular technicians to staff cardiac catheterization laboratories; the compilation of updated information on heart disease for the first international Birth Defects Atlas and Compendium, published in 1973; serving on the cardiac advisory committee for the state; contributing to several leading textbooks in pediatric cardiology; and developing comprehensive diagnostic, medical and surgical services for Florida children with congenital heart disease.

"Having the new endowed teaching positions in adult and pediatric cardiology will help UF produce more highly skilled professionals for cardiac patients of all ages," Schiebler said. "The care of children with heart disease varies significantly from that of adults because many heart defects found in children are present at birth and demand immediate attention. Most adult heart problems are a result of aging and lifestyle."

Other UF officials attending the presentation were Dr. David R. Challoner, vice president for health affairs; Alvin V. Alsobrook, vice president for university and government relations; Dr. James E. McGuigan, professor and chairman of the Department of Medicine; Dr. Richard T. Smith, vice president for advancement; and Gerald H. Eidson, associate in medical program development. Members of the AHA's Eminent Scholar Chair Committee include Bill R. Brown, John S. Hughes, Dr. Istvan Krisko, Dr. Thomas F. Raymond, and Dr. Donald E. Warren.

Nationwide eye care project launched for the elderly

A nationwide public service project will provide medical and surgical eye care to America's elderly, regardless of their ability to pay.

Sponsored by the Foundation of the American Academy of Ophthalmology, the project is called the National Eye Care Project. It begins January 6, 1986, in Washington state, and will be phased in nationwide in two- to three-week intervals in twelve multistate regions. Implementation in Florida begins March 17, 1986.

The project will operate in this fashion: if a person is age 65 or older, is an American citizen or legal resident, and does not have a personal ophthalmologist, he or she may call a toll-free number for assistance. An operator, using a computerized system, will match the caller with a nearby ophthalmologist who has volunteered to provide care.

The project's emphasis is on the needy. If a patient does not have Medicare or other health insurance — and 4 to 5% (more than one million) of elderly Americans do not, for whatever reason — then the physician's services are provided without charge.

If the caller has Medicare or other health insurance, this will pay the entire cost of the physicians's services. For this project only, volunteer ophthalmologists have agreed to accept Medicare and insurance assignment as payment in full.

The Foundation wants to reach as many of these needy elderly Americans as possible. Cataracts, glaucoma, diabetes and other conditions affecting vision need to be detected and treated promptly. In a pilot test of the project, ophthalmologists detected, in addition to eye problems, other medical problems in about 8% of all patients examined. These were referred to other physicians.

In White House ceremonies opening the pilot test, President Reagan termed the National Eye Care Project "voluntarism at its finest." Commendations have come from many organizations and individuals concerned with health care for older Americans.

Funds for the project are coming entirely from the private sector. The project is expected to cost more than $3 million to operate during 1986. About half of the money is coming from voluntary donations from ophthalmologists themselves. The remainder is coming from several major gifts from corporations associated with the eye care profession, and from other individual donors.

The project's services will be available to elderly throughout the nation by midsummer 1986. An intensive media campaign to publicize the toll-free number will be conducted as each region opens. Ophthalmologists' spouses have volunteered to aid the information effort at the local level.

The Foundation has made a commitment to operate the project indefinitely, so long as resources and volunteer medical services are available.

The goal of American eye physicians and surgeons is to ensure that every older American receives the professional medical and surgical eye care he or she needs, regardless of ability to pay.

AMA offers a workshop to assist physicians and medical office staff in maximization of office efficiency in practice

To assist physicians and medical office staff in making their practice more cost effective, the American Medical Association offers the workshop, "Managing the Business Side of Medicine."

Covering the practice management skills that every practice should have, this valuable one-day workshop gives sound, practical advice in all business areas of practice including telephone management, proper use of appointment scheduling, personnel, medical collections and more.

The workshop is conducted by professional staff of the AMA's Department of Practice Management. All are experienced educators in medical practice management, and conduct educational programs nationwide for physicians and medical office staff.

Workshops are scheduled in Miami, January 17 and April 3, 1986.

The fee for this one-day workshop includes registration, refreshment breaks and workshop materials. To register or for more information, call the AMA Practice Management Registrar collect at (312) 645-4958; or write to the American Medical Association Department of Practice Management, 535 N. Dearborn Street, Chicago, IL 60610.

☐ ENCORES!

Cost effective or quality care: which shall it be?

The title of the article was "The Role of Echocardiography in Cost-Effective Health Care." This was the latest in a series of reports submitted to my editorial office with the phrase "cost-effective health care." It is evidently fashionable to scrutinize current diagnostic and therapeutic modalities for their "cost effectiveness." Is this recent fad simply a rush to use an eye-catching phrase (such as the sadly

over-used word, parameters), or does it portend an orientation toward new priorities in the management of patients?

I submit that a cost-effective approach may be appropriate for office management or industrial technology, but it is unacceptable when applied to patient care. If the clinician makes his therapeutic decisions on the basis of "the most cost-effective" drug or medical device, is the patient aware that he or she may be receiving second-rate medical care? Informed consent has become a moral and legal necessity. This process of self-determination permits the patient to participate in final choices of treatment. Yet many current recommendations, which include cost effectiveness as a decisive force in decision making, fail to include the patient in ultimate choices.

The current annual budget for health care is $325 billion and we are told this is a financial burden that our republic cannot tolerate. Sociologists and financial planners have suggested that hospital administrators, government agencies, and third party payers work together to ameliorate this crisis. We earnestly hope that the medical profession will be called upon in key consultative roles to assist in any modifications of medical care. The participation of the physician, however, as a consultant to the government is a vastly different relationship than the individual clinician's decision to withhold treatment on the basis of cost. The physician establishes with each patient a moral contract to provide the best possible care that is available based upon his/her current knowledge. This moral contract does not permit unilateral decisions by the practitioner to choose a particular test or drug because it is "almost as good, but cheaper." Assumption of such a judgmental role is in conflict with the very basic philosophy of a distinguished profession. If society determines that there must be rationing of health care, then it is the responsibility of society to establish those laws which will be carried out by all citizens, including members of the medical profession.

Some countries now enforce arbitrary rules based upon age, which limit access to kidney dialysis or admission to intensive care units. We hope that the citizens in these countries are aware of the fact that the individual practitioner has not altered his/her relationship with the patient, but that these are administrative decisions imposed upon an entire society. Only in this way can the trust of patients be maintained so that they will recognize that it is, today as always, the clinician's desire and responsibility to offer the best conceivable medical care that society permits.

The medical profession willingly acknowledges that it will have to review medical practices in terms of the urgent need to economize. Duplication of facilities, the practice of defensive medicine, and unnecessary surgery are indeed indefensible and these errors must be corrected. However, there are ways to economize without jeopardizing the quality of care and it is the physician's responsibility to participate in such studies. At no time, however, should the clinician accept the philosophy that the medical professin may compromise its historic pledge to maintain quality of care of regardless of cost. Fiscally sound medical care need not be inferior care. Indeed, in some instances, the most cost-effective choices also offer the finest quality in medical management. However, cost should be only one of the considerations in medical decision-making and of a lesser priority than excellence.

I hope that the phrase "cost effective" will not appear in medical literature in the months ahead. I prefer titles such as "providing quality care more economically." It is entirely correct and currently appropriate to engage in studies that determine whether a particular drug, test or medical device is more economical but equally as good as the agent or test to which it is compared. We cannot do more than this as individual practitioners. Physicians should refuse to inherit the wind of patient anger when such dismay is more correctly related to governmental decisions or corporate interests.

Alfred Soffer, M.D., F.C.C.P.
Park Ridge, Illinois

Acknowledgment

I very much appreciate the assistance and encouragement of Dr. Fredric L. Coe in the preparation of this editorial.

Reprinted with permission from *Chest*, December 1985, 88:806.

Regulatory boards are working better than ever

It is ironic that consumer groups and the media now are attacking the medical regulatory system in this nation for being effete and incompetent, since these boards are doing a better job now than they have ever done.

Boards of licensure and discipline date back to 1639 in the Virginia colony, and for more than 300 years they have been almost completely ignored by the public and the media despite their almost universal failure to do what they were chartered to do. In fact, the state boards did just the opposite by often protecting the profession at the expense of patients and the public at large.

It is perhaps similarly ironic that a malpractice crisis exists now when medical practice prolongs and saves more lives than ever before.

In just the past 10 years, many boards have begun to perform their statutory roles more effectively as the arbiters of medical practice in their states. This must be attributed in great part to public interest in malpractice, the cost of care and consumer issues in general.

I must take some credit for bringing media attention to this matter by having written an article that was recently published in the *New England Journal of Medicine* (March 21, 1985). The Journal's editor, Arnold Relman, M.D., wrote an editorial comment about my article in the same issue, and it is important to note that, aside from these references, the medical and lay literature have been almost devoid of material relating to state boards and the regulatory system.

The Public Citizen Health Research Group report on medical malpractice and the need for disciplinary reform instead of tort reform reiterates data reported by me in the *New England Journal* for the year 1982 and updated by the Federation of State Medical Boards for the years 1983 and 1984.

It is quite obvious from the data that medical boards are not disciplining many physicians, and even the most efficient states, like Florida and Utah, are doing only a marginal job of removing incompetent doctors. The best states discipline just fewer than one doctor per 100 per year, and many states do not discipline any doctors at all.

The authors' editorial comments strongly affirm their opinion that the malpractice crisis has been created by bad doctors and a failure of the regulatory process. They want to halt attempts at legislative tort reform and malpractice relief, which they view as anti-consumerist and wrong, and instead make several suggestions to improve the disciplinary process.

They contend that the regulatory system is not working and suggest improvements, and they believe that bad doctors have created the malpractice crisis.

Although medical boards have improved considerably in the past decade, there is still a very long way to go. In a sense, the disciplinary system in most states is in its infancy. Although the Federation of State Medical Boards was chartered in 1912, it only recently began to compile and share disciplinary reports. The federation is a slave to its member states, which fund it through their purchase of the FLEX test for licensure applicants. Until recently the complacency of member boards engendered an inefficient parent organization.

The notion of medical regulation is unknown in most other nations of the world, including many nations in western Europe, and despite our deficiencies, we still do the best job of any other nation.

The report suggests increasing licensing fees to $500 per year per physician to make funds available to disciplinary boards; passing strong legislation to expand the size and strength of disciplinary boards; requiring insurers to experience rate doctors; requiring attorneys and the courts to file reports on doctors who have lost malpractice suits; making all other data, such as material from PRO files, available to disciplinary boards; periodically recertifying.

To comment: there is no question that more money will make better regulatory boards, and most states' medical license renewal fees are too low. The Florida board just voted to increase our fee from $50 to $100 every two years. Along with regulatory reform in 1979, there was an increase in funds available for use by the medical board from $650,000 in 1979 to $2.2 million in 1984.

In Florida, almost every detail of board activity, from the cost of renewal fees to the number of telephones and secretaries in the cramped medical office in Tallahassee, is controlled by the Legislature. This causes every request for change to become a laborious and political process. The Secretary of DPR needs more freedom to allocate funds from the licensure trust fund for specific board needs and requests.

Salaries paid to investigators, prosecuting attorneys and board personnel are often too low to attract and retain the high quality personnel needed to do the job. When a physician is charged by the board with an administrative complaint, you can be certain that he will hire the best administrator or criminal attorney his money can buy.

Federal peer review orgainzation regulations provide confidentiality for physicians whose hospital records are examined by PRO reviewers to compile data. The reviews do at times show evidence of gross overutilization of hospital resources and possible malpractice, and these findings should be made available to state regulatory boards.

The Florida Board of Medical Examiners has been trying for more than three years to get new legislation that would improve our ability to screen out possible fraudulent and incompetent graduates of certain foreign medical schools who seek licensure in Florida. Yet the Legislature has viewed this as a political problem and refused to help. What better way is there to create a future malpractice problem than to offer a deaf ear to a medical board that seeks ways to keep possibly incompetent and fraudulent physicians from obtaining a medical license in this state?

The Health Research Group also alleges that bad doctors and a failed disciplinary system have created the malpractice crisis.

In a presentation I made in October 1984 to the Medical Malpractice Task Force of the South Florida Health Action Coalition in Tampa, it was my contention then, as now, that doctors who are sued for malpractice are generally competent and sometimes

even outstanding physicians who work in areas like obstetrics, and neurosurgery. These fields are fraught with the potential for bad results. I once read that the chairmen of neurosurgery of all seven medical schools in New York City had pending malpractice suits against them.

I do not believe there is an association between a failed disciplinary system and rising rates of professional liability insurance and the size of jury awards.

Many incompetent physicians practice in rural areas, prisons, state mental hospitals and among the urban poor, and they are never sued for malpractice despite the great personal and financial harm they inflict upon their patients and society at large. Neither are these physicians generally detected by the disciplinary system, because a physician cannot be charged and disciplined without first being discovered and investigated.

Despite differences with certain aspects of their report, I welcome the Public Citizen Health Research Group report as a necessary contribution to a small but growing literature on this subject. If we think and write about incompetent physicians, malpractice and the regulatory process, then we will arrive at ways to make improvements that eventually will benefit patients and all citizens.

Although many consumer groups want to see more public members on medical boards, I believe the physician members have been the most diligent in trying to make certain that only qualified and competent physicians are allowed to receive and retain a medical license in Florida.

The disciplinary process in this state utilizes lawyers as hearing officers, and in almost every case physician medical board members want stricter discipline and more severe penalties than the hearing officer recommends. These discrepancies force some board decisions to be reversed by the appeals courts in favor of the lighter penalties suggested by the hearing officer.

A serious shortcoming of the system is the failure to investigate and discipline physicians for medical incompetence, because they are not complained about by patients or other physicians. Medical boards tend to discipline felons or doctors who over-prescribe controlled drugs.

Complaints about incompetence will only increase when physicians decide to "snitch" against colleagues who they believe have violated the law and harmed patients, and when patients become more sophisticated and less fearful about filing a complaint against a member of the medical profession.

Richard J. Feinstein, M.D.
Miami

Reprinted with permission from *South Florida Medical Review*, Vol. 1, No. 10, September 24, 1985.

Thoughts on the Medical Malpractice Reform Act of 1985

Last night I attended the Sacred Heart Hospital "Medical Malpractice Reform Act of 1985" Seminar.

As the late afternoon golden autumn sun fell slowly across the pure blue sky, punctuated with soft cotton-ball clouds, my mind, instead of enjoying the beauty of a perfect day, was troubled. The warm sun, crisp air and clear autumn sounds could not dispel the dread, bitterness and fear of the meeting. Bitterness of exchanging a relaxing evening at home for a boring and unpleasant meeting, dread of what I may hear and fear of how my practice life might be changed. A few days ago I told one of my partners I was not going because no new information regarding avoiding malpractice suits could possibly be given. There is no new advice beyond practicing good medicine, talking kindly to patients, keeping honest, accurate medical records and maintaining professional liability insurance. Nevertheless I went. I sought my wife's advice, shared the title with her and told her I really did not want to go. She thought I should go, it sounded important. So, out of duty, fear of missing something important and plain conformity (because most others would go) I went.

I was surprised when I arrived to see only a few people present. Ultimately I estimated approximately a third of the staff came. The table containing the sign-in sheets stood in the foyer. This provoked my first burst of sadness. No one trusts us anymore. Our word of honor indicating attendance is not enough. I see a "steelcase" file cabinet in a neat, decorously (if not luxuriously) decorated administration office filled with 1/3 cut manila file folders with neatly typed labels: Westmark, Edward R., and similarly for each staff member. This file is cold, sterile and dead. It does not possess honesty, honor, integrity or any other human quality. It contains a green and white ruled computer paper depicting us as a set of attendance numbers. Pure arithmetic. Mathematics is beautiful but it is not us and we do not want to be numbers. Sad! And how ironic. We, the alleged perpetrators of "dehumanized medical care" are ourselves being dehumanized to performance and attendance numbers, and we abhor it. Is it true we are no longer trustworthy and must be monitored so closely? Our patients say we cannot be trusted. Our government says we cannot. Our jurisprudence systems says we cannot. Our hospitals say we cannot. If it is true a sad era is upon us. If it is not true, why do we accept the allegation so passively?

I walked into the auditorium. It was filled with rows of tables stretching from wall to wall. The first time I had seen it so. In the rear a buffet dinner gave

off the tantalizing scent of fried chicken. Appetizing vegetables, iced tea and soft drinks complemented the chicken. Surely, I thought, this is the historic last meal of a "condemned criminal." I had already eaten so I chatted with colleagues. Their talk was the joking, nervous "gallows humor" that precedes an event of great import in our lives. I saw it before each big test in medical school. I thoughtfully studied their faces. They were lined and drawn with dilated pupils. Fear showed. Their demeanor was one of listless resignation. "I do not want to be here. Let's have the bad news and get it over with." The ubiquitous "Medicine is no longer fun to practice" and "If I can just make it another 5, 7 or 10 years and get my retirement plan funded I am quitting" resounded. Sad! Frustrated, unhappy, besieged, angry, hard working, intelligent men and women feeling helpless and betrayed. A life of service that in earlier years promised satisfaction, now soured, ruined and drudgery. Worsening, all the while.

As I sat waiting and thinking I was introduced to the speaker. A pleasant "yuppie" appearing young man, with well cut dark grey pin-striped suit, white shirt and decorously patterned red tie. Social smile and outgoing manner. Neat and intelligent. At his formal program introduction I learned he was an attorney for the Florida Hospital Association. I jolted at this news. Why should the medical staff be listening to the Medical Malpractice Reform Act explained by the hospital's attorney? Should we not have it explained to us by a medical staff attorney? No matter. I am sure we are being given the perception that we are one of the cooks when in truth we are part of the ingredients.

We each received a handout containing a "detailed summary of HB 1352." I thought about the title of the bill. "The Medical Malpractice Reform Act of 1985." The dictionary defined reform as: 1. the improvement or amendment of what is wrong, corrupt, etc. 2. amendment of conduct. 3. to restore to a former and better state; improve by alteration, substitution, abolition, etc. 4. to cause a person to abandon wrong and evil ways of life or conduct. 5. to put an end to abuses, disorders, etc.

Since we are the only people who practice medicine, we are the only ones who can commit medical malpractice. The bill, therefore, must be addressing us (physicians). How did we fall so far, so fast to deserve the adjectives wrong, corrupt, evil, abusive and disorderly. My head was spinning. Once we were respected and loved. Now the legislature, representing all our patients, is compelled to reform us. It is true, we are evil, do wrong and abuse, but no more than our patients. We are human. I watch my colleagues at work and I do not see evil, abuse and wrongdoing. I see intensely interested, caring physicians working as hard as humanly possible to cure their patients. The problem is we are not allowed any normal, human errors. If we become mortal and make any mistakes we are labelled "in need of reform." We must achieve perfection and that has only been done by one person, Jesus Christ, in all of history. Our predicament is impossible. We are caught in a great tidal wave of hostile social change seeking the impossible.

Each week I receive so many directives, announcement, rulings, newsletters and reports from the hospital, AMA, FMA, Federal Government, Escambia County Medical Association and State government that I cannot keep up with them nor long remember them. And this does not count keeping up with the legitimate scientific body of medical information that becomes obsolete every 5 years. Then I am admonished by all to "be involved." My community, my church and my family need me. I feel I am "involved," over-involved, in a hostile world that no longer likes or appreciates physicians, indeed, now finds us to be a scourge and the cause of many of its troubles.

My reverie ended as the explanation of 36 of 46 sections in the bill began. Immediately with the first section, questions were asked. The young attorney answered them from the hospital's viewpoint. When queried about the doctors' standpoint he had no answer. He clearly, affably and politely wove his way through sections dealing with our staff memberships, clinical privileges, medical staff discipline, Department of Professional Regulation discipline, cooperation and insurance carriers, Hospital Quality Assurance, Hospital Risk Management, punitive damages, pre-suit screening, arbitration, attorneys' fees, pretrial settlement conferences, joint and several liability, unnecessary diagnostic testing, risk management education and peer review records. Each nicely explaining how the hospital will approach them. I was and still am angry, frustrated and resigned to an unhappy decade of medical practice. I feel already convicted without benefit of trial and out on probation. All will be fine if I follow everybody's rules and am careful not to be human and ever make a mistake. If I do, a dozen reports will immediately emanate to various committees and my career may silently and softly end with dismissal from the medical staff and loss of license. All because I tried hard to abide by an impossible and increasing number of rules that tell me I am not to be trusted as an honest and competent physician. The psalmist captures my feelings in Psalm 25 Verses 17 and 18: " The troubles of my heart have multiplied; free me from my anguish. Look upon my affliction and my distress and take away all my sins."

All left the meeting despondent. What can we do? Nothing. Hurry home, catch the second half of Monday night football and wait for the inexorable pendulum swing. Paul in 2 Corinthians 4:8 and 9

knew and expressed our feelings best: "We are hard pressed on every side, but not crushed; perplexed but not in despair; persecuted but not abandoned; struck down, but not destroyed.

Edward R. Westmark, M.D.
Pensacola

Reprinted with permission from *The Escambia County Medical Society Bulletin*, December 1985.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The altered script scam"

Prescribers who short-cut proper prescription writing practice, especially those who use arabic-numerals for dose amounts (not reinforced by a written number), are easy marks for professional patients. By simply matching the ink color of the prescribers pen or ball-point, a prescription for 10 can become a prescription for 40, 5 can become 25. A prudent prescription becomes excessive, and proportionally more profitable to the professional patient.

Caution • Prescribers are cautioned to always follow good prescription writing practice; use ink or indelible pencil; write out actual amount of medication prescribed in addition to Arabic or Roman numerals and never leave prescription pads unattended.

CORRECTION

The following chart should have appeared on page 947 of the November issue of *The Journal* (Vol. 72, No. 11) instead of the chart that was shown.

Table 1. — Prenatal Care by Age and Number of Visits

	Age		
	≤ 19 years	≥ 20 years	Total
No. of Visits	n(%)	n(%)	n(%)
0	5(10%)	5(10%)	10(10%)
1-4	9(19%)	5(10%)	14(14%)
5-8	10(21%)	19(36%)	29(29%)
≥ 9	24(50%)	23(44%)	47(47%)
Total	48*(100%)	52**(100%)	100(100%)

* 2 missing responses
** 1 missing response

MEDICAL DIRECTOR

National health care organization seeks full and part-time Medical Directors for interdisciplinary back rehabilitation centers currently under development in several locations in Florida as well as other areas in the southeast. Background preferred in physical medicine, neurology or primary care, but other specialties will be considered in light of experience in field. Please send resumes to:

Bruce Hutson, M.D.
National Rehabilitation Centers, Inc.
109 Westpark Drive
Suite 450
Brentwood, Tennessee 37027

Or call 1--800-354-2225.

GIFTS FROM FLORIDA

Deluxe citrus and superb pecans.

Send gift boxes in the U.S., Canada, or Europe via jet.

We guarantee the finest products available — Hand packed in attractive gift boxes — Special fast delivery.

Place your Christmas Gift Orders **Now.**

Brochures available from local county FMF Chairman or President or . . .

Florida Medical Association Auxiliary

Mrs. Gary M. Wright
4171 S.E. 38th Street
Ocala, Florida 32671
(904) 694-2284
(904) 732-4032

Profits go to the Florida Medical Association. Cost is 25% — TAX DEDUCTIBLE.

Physicians' Confidential Assistance

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

BOOK REVIEWS

Book Review Editor — F. Norman Vickers, M.D.

Beyond the next mountain: an autobiography by Robert Crawford Woodward, December 9, 1867 — August 31, 1949

Privately printed by Jewell W. Alderman and Mae Knight Clark, 122 pages, Price $14.95. Banyan Books.

There are those among us for whom adversity serves as a springboard to greatness. Such a one was Robert Crawford Woodward, M.D. In this autobiography, published several months ago, the central theme is the ingenuity, vigor and persistence with which Woodard met seemingly insurmountable problems and overcame them. To put his philosophy in his own words: "But in all this, my resolution to succeed in life was so firm, so intense, that I never for a moment gave thought to the possibility of failure in anything that might be undertaken."

Woodard was born to a South Georgia family shortly after the Civil War. His family, once wealthy plantation owners, were barely able to feed and clothe themselves in those stringent times. By dint of hard work, first on the farm and later as an accountant, he obtained a public school and business school education. He served as a teacher and later superintendent of schools in Adel, Georgia. His thirst for knowledge still not satisfied, he determined to go to medical school and become a physician. With financial help from friends and the State of Georgia, and with steadfast support from his wife and family, he attended the full course of study at the Medical Department of the University of Georgia in Augusta, graduating with honors.

He set up practice in Cecil, Georgia, but after six months moved to Adel, Georgia, where he practiced medicine and surgery and with another physician built the first hospital in that area. A community-minded man he continued to work with the school system and took a keen interest in local politics. Indeed, he became adept at representing his area in the state legislature and spearheaded the drives that esatablished three south Georgia counties: Cook, Lanier and Lamar.

Hard times fell on South Georgia when the boll weevil came to destroy the "money crop," Sea Island cotton. Again Woodard was dogged by adversity. Looking for an area where he could better provide for his family, he visited his nephews in Miami. Things were much more promising here so he moved his family down and opened a practice here in late 1921. There followed the heady days of the real estate boom, the devastating hurricane of 1926 and again the economic hard times of the great depression.

Woodard took an active part in the medical community and was elected president of the Dade County Medical Society in 1927. He also took a keen interest in civic affairs and was represented by the "movers and shakers" of the community. In 1931, the Miami City Commission appointed him superintendent of the James M. Jackson Memorial Hospital. This appointment initiated one of the most challenging periods of Woodard's life. At this time money was scarce and yet there was great need for the modernization of the hospital facilities and the provision of more beds. This autobiography provides much insight into the problems of that period, how they were addressed and the names of those who, with the constant goading of Woodard, brought the hospital to the first rank of the nation's hospitals by the beginning of World War II.

A heart attack in 1940 forced Dr. Woodard to resign his position as superintendent. After a convalescent period, he opened his office on Northwest Twelfth Avenue where he practiced general medicine until his death from heart disease in 1949. Always eager for knowledge he continued to take postgraduate courses and attend conferences up until his final illness.

Georgia history buffs will find his small volume a source of material on daily life in South Georgia and Georgia politics during the first two decades of this century. Dade County historians will find it useful in the study of the depression days of South Florida, especially as they affected the Jackson Memorial Hospital during those stringent times. All readers will find his life an inspiration and a stimulus to redouble their efforts when going gets rough.

William M. Straight, M.D.
Coral Gables

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

THE FLORIDA MEDICAL ASSOCIATION INC. 1874

Your Avis AWD Number:
A/A 616900

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

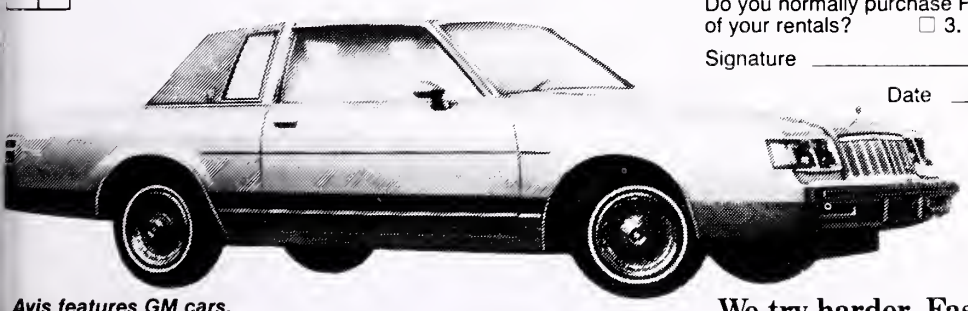
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

lat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in lanhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ; LaGuardia Airport, NY; JFK Airport, NY and ll Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling ervice charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

Avis Rent A Car System, Inc., Avis®

3/85 Printed in U.S.A.



Rx for fine dining:

—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desser including many outstanding game, seafoo and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.

KEY LIME PIE

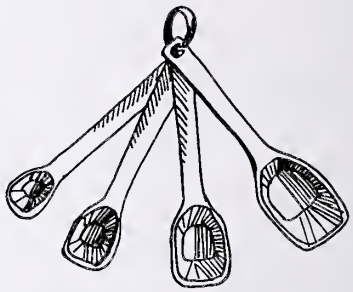
"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used.

Mrs. Michael John Murray (Candy)
Lee County



Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!



Among so many once-daily antihypertensives, only one can offer so much...



© 1985 Ayerst Laboratories

Once-daily INDERIDE® LA

The world's leading beta blocker and diuretic—for once-daily convenience without compromise

When selecting other once-daily agents, physicians may have to compromise either their choice of beta blocker or diuretic. With INDERIDE® LA, physicians have the agents most widely prescribed worldwide—INDERAL® and hydrochlorothiazide—with the convenience of once-daily dosage.

24-hour blood pressure control with the broad benefits of INDERAL (propranolol HCl)

The controlled-release delivery system of INDERIDE LA provides 24-hour beta blockade and the broad cardiovascular benefits of INDERAL with a single daily dose. Compliance is enhanced because once-daily administration fits easily into patients' daily routines.

Plus standard-release hydrochlorothiazide, the thiazide of choice for comfortable morning diuresis

Hydrochlorothiazide is the world's most widely prescribed antihypertensive diuretic. When taken in the morning, INDERIDE LA provides comfortable morning diuresis. Each dosage strength of INDERIDE LA contains:

—one of the three most widely prescribed dosage strengths of INDERAL® LA—80 mg, 120 mg, or 160 mg and

—an established, effective daily dose of standard-release hydrochlorothiazide—50 mg

New once-daily

INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg

Convenience without compromise



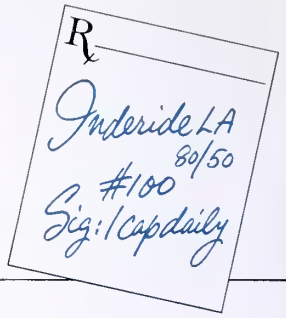
80/50 120/50 160/50*

*The appearance of INDERIDE® LA Capsules is a registered trademark of Ayerst Laboratories.

Please see following page for brief summary of prescribing information.

Once-daily
INDERIDE® LA
Convenience without compromise
One capsule—Once daily





* The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERIDE® LA Brand of **PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)**

No. 455—Each INDERIDE® LA 80/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 80 mg
Hydrochlorothiazide 50 mg

No. 457—Each INDERIDE® LA 120/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 120 mg
Hydrochlorothiazide 50 mg

No. 459—Each INDERIDE® LA 160/50 Capsule contains
Propranolol hydrochloride (INDERAL® LA) 160 mg
Hydrochlorothiazide 50 mg

INDERIDE LA is indicated in the management of hypertension.

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias; headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

Ayerst® AYERST LABORATORIES
New York, NY 10017

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

The first male spouse in the Dade County Auxiliary

I never intended to be a pioneer, and I never expected to be the first male member of the Dade County Medical Association Auxiliary, but here I am with this singular honor and privilege.

Nancy, my wife, has been a physician for 24 years. I have been married to Nancy for 26 years, and we have accumulated five children. Is it any different for a male spouse than it is for a female spouse? That is a good question. The answer is probably no.

We suffered through medical school together as you did, and then, in turn, internship and two residencies; pediatrics and psychiatry. Her on-call nights traumatized all of us the same way yours did, and our telephone still causes the same separation that yours does.

Maybe there were some things that were different. When Nancy stayed at the hospital overnight, I would march the children down and we would all sleep there overnight together and wait to take her home again. When she became Chief of Psychiatry at Miami Children's Hospital, I became the administrator of the division so that the children and I could see her frequently.

I took a lot of love and caring, and I think if I were to really answer the question and how it feels to be the male spouse of a physician, I would have to say that the real question is how did a woman become a physician, rear five children, and stay married to me for 26 years? Possibly becoming a therapist myself so that we could continue to work together made the difference. Her profession as a child psychiatrist has had a profound influence on the raising of our children.

All we really did over the years was to adjust to each other's needs both personally and professionally. Maybe that is how we were successful at it. But did you all not do the same thing?

Unlike the previous new members, my participation is, I am sure, going to be much more noticed than have new members in the past. I will be getting used to discussions involving "our husbands," remembering that "ladies" does include me. It is impressive for all of us to realize that 30 percent of the physicians in Florida today are women. That means a large number of male spouses are eligible for membership in the medical auxiliary.

I only hope that my pioneering days will quickly be over as far as the medical auxiliary is concerned. Come on fellow male spouses and join me. Honestly, it is not really lonely here at the top, and I think that all the members together can really help to make the Auxiliary a fantastically dynamic organization.

In any case I am thrilled to be one of the first males to be a member of the Dade County Medical Association Auxiliary, and I hope that my participation will be up to the standards set by my fellow members during the 22 years that I have waited for the privilege.

Melvin C. Greenfield, Ph.D.
Miami

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN

If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

THE WORLD BOOK ENCYCLOPEDIA is now available through the FMA Magazine Program. Write or call for complete details of any current promotional offer.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

WE ARE REPRESENTATIVES FOR WORLD BOOK ENCYCLOPEDIA!
Special: $100 off for educators until 12/3/85

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
erican Artist(12)	19.00	19.00	10.97(9)
erican Cage-Bird(12)	15.00	12.00	12.00
erican Health(10)	14.95	12.95	11.95
erican Heritage(6)	24.00	18.00	18.00
er.Photographer(12)	19.90	9.95	6.65(8)
2 yrs(24)		19.90	
ericana(6)	11.95	11.95	9.95
alog:Sci-Fi(13)	19.50	19.50	9.97(10)
tique Monthly(18)	18.00	18.00	13.00(12)
tNews(12)	29.95	25.95	25.95
tist's Mag(12)	21.00	21.00	9.97(9)
ts & Antiques(10)	36.00	29.95	29.95
imov Sci-Fi(13)	19.50	19.50	9.97(12)
tronomy(12)	21.00	21.00	15.75(9)
lantic Monthly(12)	9.95	9.95	9.95
tenzione(11)	21.00	21.00	7.97(8)
ilo(12)	17.94	17.94	8.97
dubon Magazine(6)	16.00	16.00	15.00
to Racing Digest(6)	7.95	7.95	5.97
tkpacker(6)	18.00	14.97	14.97
seball Digest(12)	14.95	14.95	7.97(10)
sketball Digest(8)	9.95	9.95	7.97
uty Digest(12)	15.00	15.00	15.00
tter Health/Liv.(6)	15.00	15.00	11.97
ttter Hms-Gdns(12)	12.97	6.49	
icycling(10)	15.97	8.00	11.97
d Watchers Dig(6)	11.00	11.00	11.00
ck Enterprise(12)	15.00	9.00	7.50
ting(12)	20.00	16.97	16.97
n Appetit(12)	15.00	15.00	15.00
rling Digest(6)	12.00	12.00	9.97
rs Life(12)	13.20	13.20	11.97
des(6)	12.00	9.00	
2 yrs(12)		16.00	
& Driver(12)	17.00	11.99	11.99
Craft(12)	12.94	12.94	7.97
s (12)	17.50	17.50	12.50
Fancy(12)	17.97	17.97	12.97
nging Times(12)	15.00	9.97	9.97
ld Life:age 6-10(8)	11.95	11.95	9.97
ldrens Dig:7-11(8)	11.95	11.95	9.97
ldrens Playmate(8)	11.95	11.95	9.97
cle Track(12)	19.95	11.95	11.95
nage(12)	14.00	14.00	11.95
lectors Mart(6)	18.00	18.00	15.96
umbia Journ.Rev(6)	16.00	16.00	9.95
mentary(12)	33.00	33.00	33.00
nnoisseur(12)	19.95	10.00	19.95
sumers Reports(12)	16.00	16.00	16.00
s.Rep.Travel Letter(12)		37.00	37.00
fts Magazine(12)	15.00	15.00	15.00
ss Country Ski.(5)	11.97	9.97	8.97
ise Travel(6)	12.00	7.97	12.00
ising World(12)	18.00	18.00	14.00
le(12)	14.00	14.00	6.99
le World(12)	13.94	13.94	6.97
time TV(12)	19.00	19.00	12.95
ital Audio(12)	19.97	19.97	16.97
scover(12)	24.00	13.00	14.95
2 yrs(24)		26.00	
Fancy(12)	17.97	17.97	12.97
World(12)	20.00	20.00	14.97
nbeat(12)	15.75	15.75	7.95
ny(12)	16.00	14.00	9.97
Economist(52)	85.00	51.00	51.00
ery Queen Myst(13)	22.75	19.50	9.97(10)
uire(12)	17.94	9.95	9.95
ence(12)	12.00	12.00	9.00
t(12)	22.00	22.00	18.00
lly Circle(17)	14.97	14.97	

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
Family Computing(12)	19.97	11.97	11.97
Family Handyman(10)	9.95	9.95	5.95
Field & Stream(12)	13.94	7.94	7.94
2 yrs(24)		15.88	
Fifty Plus(12)	15.00	11.97	
2 yrs(24)		23.94	
Financial World(26)	41.95	24.94	18.95(18)
Fishing/Hunt.News(52)	29.95	29.95	21.95
Flying(2)	19.00	15.97	15.97
Food and Wine(12)	18.00	9.00	15.00
2 yrs(24)		18.00	
Football Digest(12)	12.95	12.95	7.97(10)
Forbes(28)	42.00	42.00	28.00
Fortune(26)	42.00	21.00	21.00
Forum(12)	18.00	18.00	15.00
Games Magazine(12)	15.97	15.97	15.97
2 yrs(24)		24.97	
Gentlemens Quart.(12)	18.00	13.50	
2 yrs(24)		27.00	
Glamour(12)	15.00	12.00	
2 yrs(24)		22.00	
Golf Digest(12)	19.94	9.97	9.97
Golf Illustrated(12)	12.00	12.00	6.00
Golf Magazine(12)	15.94	8.97	7.97
Good Housekeeping(12)	14.97	14.97	14.97
Gourmet(12)	18.00	13.50	15.00
2 yrs(24)		25.00	
Great Foods Mag.(6)	9.95	9.95	7.95
#Harpers Bazaar(12)	16.97	8.97	16.97
Harpers Magazine(12)	18.00	11.97	11.97
Health(12)	22.00	15.97	11.00
High Fidelity(12)	13.95	6.98	6.98
High Technology(12)	21.00	21.00	15.00
Hitchcock Mystery(13)	19.50	19.50	9.97(10)
Hockey Digest(8)	9.95	9.95	7.97
Home(12)	15.00	15.00	11.97
Home Mechanics (12)	11.94	6.94	6.94
2 yrs(24)		13.88	
The Homeowner(10)	18.00	13.97	7.50
Horizon(12)	21.00	21.00	16.00(10)
Horseman(12)	11.95	11.95	7.95
Hot Rod(12)	13.94	13.94	8.97
House and Garden(12)	24.00	18.00	
2 yrs(24)		36.00	
#House Beautiful(12)	15.97	7.99	15.97
Humpty Oumpty:4-7(8)	11.95	9.97	9.97
Hunting(12)	13.94	13.94	9.97
Inc(12)	24.00	12.00	12.00
Income Opportun.(12)	7.95	7.95	3.98(10)
Infoworld(51)	31.00	29.58	29.58
Inside Sports(12)	18.00	11.97	9.97
2 yrs(24)		23.94	
Instructor(9)	20.00	20.00	12.97
Jack & Jill:age 6-8(8)	11.95	9.97	9.97
Jerusalem Post(24)	18.46	18.46	15.97
Jet(52)	36.00	30.00	26.00
Jr. MD: age 9-13(4)	11.95	11.95	8.95
Ladies Home Jrnl(12)	20.00	17.97	10.00
Learning(9)	18.00	18.00	9.90
#Life(12)	27.00	13.50	22.50(10)
M:Civilized Man(12)	24.00	24.00	24.00
2 yrs(24)		42.00	
Mademoiselle(12)	15.00	12.00	
2 yrs(24)		22.00	
Medical Update(9)	12.00	12.00	9.95
Metropolitan Home(12)	15.00	7.50	7.50
Modern Photography(12)	13.98	7.98	6.99
Modern Screen(6)	14.70	14.70	11.70
#Money(12)	29.95	15.00	19.95
Mother Earth News(6)	18.00	18.00	14.97

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
Mother Jones(12)	18.00	12.00	12.00
Motor Trend(12)	13.94	7.97	7.97
#Motorboat.& Sail(12)	15.97	7.97	15.97
Motorcyclist(12)	11.94	6.97	6.97
MS Magazine(12)	16.00	10.97	10.97
2 yrs(24)		21.94	
Musician(12)	18.00	18.00	10.97
National Geograph(12)	16.50	16.50	16.50
Nat'l Geogr.World(12)	9.95	9.95	9.95
National Lampoon(12)	9.95	9.95	9.95
National Law Jnl.(52)	55.00	55.00	27.50
The Nation (52)	28.00	28.00	9.95(24)
Natural History(12)	20.00	15.95	15.95
Needle and Thread(6)	14.00	14.00	10.50
Needlcrft.for Today(6)	14.00	14.00	10.50
New England Journal of Medicine(52)			
Physicians:		55.00	
Residents and Interns:		35.00	
Students:		30.00	
New Age Journal(12)	18.00	18.00	15.00
New Republic (52)	48.00	48.00	28.00
#New Shelter(9)	10.97	5.50	9.97
2 yrs(10)		10.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95
New Yorker(52)	32.00	32.00	20.00
2 yrs(104)		52.00	40.00
Newsweek(52)	41.00	20.80	20.80
2 yrs(104)		41.60	
Nursing Life(6)	12.95	12.95	12.95
Old House Journal(12)	16.00	13.95	13.95
Omni(12)	24.00	15.96	15.96
1001 Home Ideas(12)	22.00	15.97	11.00
Opera News(17)	30.00	30.00	24.95
Organic Gardening(12)	12.97	9.97	9.97
Outdoor Life(12)	13.94	6.97	7.97
2 yrs(24)		13.94	
Outside(10)	16.00	12.00	8.97
Ovation(12)	16.00	8.00	8.00
PARENTS(12)	18.00	9.00	11.95
2 yrs(24)		18.00	
Penny Power:Age 9 up(6)		11.95	11.95
Penthouse(12)	36.00	30.00	30.00
People(52)	51.50	51.50	25.75
Personal Computing(12)	18.00	18.00	8.97(9)
Petersens Photog(12)	13.94	6.97	6.97
Playbill(12)	15.00	15.00	15.00
Playboy(12)	22.00	19.00	19.00
Playgirl(12)	20.00	20.00	17.50
Popular Bridge(6)	9.95	9.95	7.95
#Popular Mechanics(12)	13.97	7.00	13.97
Popular Photogr.(12)	11.97	5.99	5.99
Popular Science(12)	13.94	7.97	7.97
2 yrs(24)		15.94	
Present Tense(4)	14.00	8.77	8.77
#Prevention(12)	13.97	7.00	13.97
2 yrs(24)		13.97	
Pro Football Wkly(33)	39.00	39.00	17.00(15)
Psychology Today(12)	15.99	12.97	12.97
2 yrs(24)		25.94	
Radio Electronics(12)	15.97	11.97	11.97
Reader's Digest(12)	15.41	15.41	15.41
#Redbook(12)	11.97	6.97	11.97
Road and Track(12)	17.94	10.99	10.99
Rolling Stone(26)	19.95	19.95	17.95
The Runner(12)	16.97	12.97	8.65(8)
#Runner's World(12)	19.95	10.00	12.97
2 yrs(24)		19.95	
Sail(12)	21.75	21.75	21.75
2 yrs(24)		38.00	
Salt Water Sptsmn(12)	18.00	18.00	18.00

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
Saturday Eve.Post(9)	12.97	12.97	12.97
Saturday Review(6)	16.00	16.00	12.00
Savvy(12)	12.00	12.00	6.00
Science '85(11)	18.00	18.00	13.95
#Science Digest(12)	13.97	6.99	13.97
The Sciences(12)	12.00	12.00	12.00
Scientific Amer.(12)	24.00	24.00	24.00
Sea Magazine(12)	15.94	8.97	8.97
Self(12)	15.00	12.00	N.A.
Seventeen(12)	13.95	13.95	13.95
Shape(12)	20.00	20.00	8.97(6)
2 yrs(24)		35.00	
Ski(8)	11.94	6.97	6.97
Skiing(7)	9.98	4.99	4.99(7)
Skin Diver(12)	13.94	6.97	6.97
Soap Opera Digest(26)	39.00	39.00	29.75
Soccer Digest(6)	7.95	7.95	5.97
Sport(12)	17.50	9.97	7.97
Sporting News(26:6 mo)	22.50	12.88	12.88
#Sports Afield(12)	13.97	6.99	13.97
Sports Fitness(12)	26.50	26.50	26.50
#Sports Illustr.(52)	53.50	32.00	26.75(54)
The Star(52)	32.00	19.98	19.98
Stereo Review(12)	9.97	4.99	4.99
Stereophile(12)	20.00	14.97	14.97
Success Magazine(12)	17.94	17.94	8.97
Superfit(6)	14.97	11.97	9.97
Teen(12)	12.95	7.95	6.95
Teen Beat(12)	11.95	11.95	10.95
Tennis(12)	17.94	8.97	8.97
Theatre Crafts(10)	24.00	14.95	14.95
#Time(52)	58.25	29.25	28.00(50)
#Town & Country(12)	24.00	12.00	24.00
Tours & Resorts(6)	12.00	9.97	9.97
Travel & Leisure(12)	25.00	12.50	25.00
True Story(12)	14.95	8.97	8.97
Turtle: pre-school(8)	11.95	11.95	9.97
TV Guide(52)	31.20	31.20	26.00
Twilight Zone(6)	15.00	11.97	11.97
USA Today(260)	92.00	92.00	78.00
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50
2 yrs(104)		41.00	
U.S.News Washington Letter		39.00	39.00
Us Magazine(26)	23.95	17.95	14.95
Vanity Fair(12)	12.00	9.00	
Vegetarian Times(12)	19.95	14.95	14.95
Venture(12)	18.00	18.00	9.00(15)
Video(13)	15.00	15.00	7.50
Video Review(12)	12.00	6.97	6.97
Village Voice(52)	32.76	32.76	16.50
Vogue(12)	24.00	21.00	
W Magazine(26)	26.00	23.00	17.95
Wash.Post Nat.Wkly(26)	52.00	52.00	52.00
Weight Watchers(12)	13.97	11.97	11.97
W.Coast Rev of Bks(6)	12.00	8.94	8.94
Wind Surf Magazine(12)	19.00	17.95	17.95
Winning[Bicycle](12)	19.95	17.95	17.95
Woman's Day(17)	15.13	15.13	15.13
Women's Sports(12)	12.95	12.95	8.95
Workbasket(6)	6.00	6.00	5.00
Workbench(6)	6.00	6.00	5.00
Working Mother(12)	11.95	9.95	9.95
Working Woman(12)	18.00	12.00	15.00
World Press Review(12)	17.95	17.95	11.98
World Tennis(12)	15.94	15.94	7.97
Writer's Dig.(9 iss)	18.00	9.97	9.97
Yachting(12)	20.00	20.00	16.97
Yankee (Colonial)(12)	15.00	15.00	12.97
YM(12)	14.00	10.95	10.95
#Business Card needed for Office Price			

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLM0985

Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

JANUARY

Florida Thoracic Society 8th Annual Pulmonary Winter Course, Jan. 9-12, Contemporary Hotel, Lake Buena Vista. For more information: Milton Braunstein, M.D., 12901 N. 30th Street, Tampa 33612, (305) 463-3131.

Thirty-first Annual Cardiovascular Seminar, Jan. 10-11, Sheraton Sand Key Resort, Clearwater Beach. Contact: Anita Godsey, P.O. Box 7188, St. Petersburg, FL 33734, (813) 526-6000.

Omni-Specialty Medical Update, Jan. 12-14, Naples Bath and Tennis Club, Naples. Contact: James Marion, M.D.

One-Day Diabetes Management Course, Jan. 13, University of South Florida, Tampa. Contact: Anthony Morrison, (813) 974-4360.

The Economic Impact: Drug Abuse in the Work Force, Jan. 15-17, James L. Knight International Club, Miami. Contact: Conference Center, 400 S.E. 2nd Avenue, Miami, FL 33131, (305) 372-0140.

Eighteenth Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 15-18, Sheraton Bal Habor, Miami Beach. Contact: Victor A. Poktano, M.D., Dept. of Urology, 6614 Miami Lakes Drive East, Miami Lakes, FL 32014, (305) 687-1367.

Cardiology Tutorials in the Wilderness, Jan. 18-25, Canoe Trip, Everglades. Contact: Peter E. Pool, M.D., UCSD School of Medicine, La Jolla, CA 92093, (619) 452-3940.

Eleventh Annual Review and Recent Practical Advantages in Pathology, Jan. 19-24, Hyatt Hotel, Miami. Contact: A. Morales, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6437.

Symposium on Cancer Biology and Therapeutics, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: J. G. Cory, Ph.D., Medical Center, Box 46, 12901 N. 30th Street, Tampa, FL 33612.

MedTech '86, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: International Conference Management, c/o The Madison, 15851 Dallas Parkway, Suite 1155, Dallas, TX 75248, (214) 458-7011.

Annual Symposium on Cancer Biology and Therapeutics, Jan. 20-22, USF College of Medicine, Tampa. Contact: Joseph Cory, Ph.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

Practical Imaging of the Head and Spine, Jan. 23-26, Palace Hotel, Lake Buena Vista. For More info: Lawrence Muroff, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813)873-2090.

Digital Radiography, Jan. 23-26, Palace Hotel, Lake Buena Vista. For more info: Lawrence Muroff, (813) 873-2090.

AIDS: Epidemic of the 80's, Jan. 24, Hyatt Regency, Miami. Contact: Sharron Shelton, 33 Millwood, Mill Valley, CA 94941, (415) 361-5600.

MRI/CT Ultrasound Correlations, Jan. 26-30, Sheraton Bal Harbour, Bal Harbour. Contact: Lucy R. Kelley, P.O. Box 343762, Coral Gables, 33134.

A Practical Approach to Solutions and Problems in Burn Care, Jan. 30-Feb 1, Clearwater Beach. Contact: C. Wayne Cruse, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

Vascular and Pulmonary Diseases: Diagnosis and Management, Jan. 31-Feb. 2, Don Cesar Hotel, St. Petersburg. Contact: Stephen E. Mattingly, (303) 798-9682.

FEBRUARY

Ultrasound Integrated into Modern Ob-Gyn, Miami Beach. Contact: William A. Little, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6944.

Internal Medicine — Selected Aspects, Feb. 1-8, Telluride, Colorado. Contact: Gloria Allington, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Twelfth Annual Bail Conference in Anesthesiology, Vail, Colorado. Contact: Brian Craythorne, M.D., P.O. Box 016960, Miami, FL 33101, (305) 547-6411.

Controversies in Carcinoma of the Breast, Feb. 1-8, Snowmass, Colorado. Contact: Martin Silbiger, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-2538.

Eighteenth Miami Winter Symposium — Advances in Gene Technology, Feb. 3-7, Hyatt Regency Hotel, Miami. Contact: William J. Whelan, P.O. Box 016960, Miami, FL 33101, (305) 547-6265.

Ninth Annual Advanced Ultrasound Seminar, Feb. 5-8, Palace Hotel, Lake Buena Vista. Contact: Lennard Greenbaum, M.D., Orlando Regional Medical Center, Orlando 32806-2093, (305) 841-5144.

Hair Replacement Surgery for the Beginner, Feb. 5-9, Miami Airport Hilton, Miami. Contact: Sorrel S. Risnik, M.D., 9065 S.W. 87 Ave., Suite 109, Miami, FL 33176, (305) 279-6060.

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 6-8, Hyatt Regency, Miami. Contact: Thelma MacGregor, 1400 N.W. 12th Avenue, Miami 33136.

Twenty-third Annual Neuro-ophthalmology Course, Feb. 6-8, Sonesta Beach Hotel, Key Biscayne. Contact: Hilary Hose, 6125 S.W. 31 Street, Miami, FL 33155, (305) 667-7060.

ECG Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, M.D., 4057 Carmichael Avenue, Jacksonville 32207, (904) 398-5667.

Flexible Sigmoidoscopy Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, 4057 Carmichael Avenue, #229, Jacksonville 32207, (904) 398-5667.

Fortieth Regional Family Practice Weekend, Feb. 7-9, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, FAFP, 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

Urologic and Potential Problems in Pregnancy, Feb. 10-12, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Pulmonary, Allergy and Infectious Diseases, Feb. 10-14, Palace Hotel, Lake Buena Vista. Contact: Udaya Prakash, M.D., 200 1st Street, S.W., Rochester, MN 55905, (507) 284-2511.

Communicating with Patients, Feb. 13-14, Hyatt Regency, Tampa. Contact David H. Smith, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-3294.

Economics of Diagnostic Imaging, Feb. 13-14, Palace Hotel, Lake Buena Vista. Contact: Lawrence Muroff, (813) 873-2090.

Pediatrics for the Practitioner, Feb. 14, USF College of Medicine, Tampa. Contact: Herbert Pomerance, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4214.

Seventh Annual International Gastroenterology Conference, Feb. 16-20, Hilton Hotel, Lake Buena Vista. Contact: Sidhi Tewari, M.D., (305) 841-5144.

Strategies in Oncology/Hematology for the Family Practitioner, Feb. 17-22, Saddlebrook Resort, Tampa. For more information: Marge Adey, 42nd Dewey Avenue, Omaha, Neb. 68105, (402) 559-4152.

Conference on the Beach, Feb. 17-22, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., P.O. Box 1990, Daytona Beach, FL 32015, (904) 254-4051.

Sarasota Vitreoretinal Update Course, Feb. 20-22, Colony Beach and Tennis Resort, Longboat Key. Contact: James Kingham, M.D., (813) 921-5335.

Practical Aspects of Newer Cardiovascular and Renal Drugs, Feb. 20-23, Orlando. Contact: University of Miami, Division of CME D23-3, P.O. Box 016960, Miami, 33101, (305) 547-6716.

Pediatric Dermatology Seminar, Feb. 20-23, Eden Roc Hotel, Miami Beach. Contact: Guenter Kahn, 16800 N.W. 2nd Avenue #401, N. Miami Beach, FL 33169, (305) 652-8600.

Thirteenth Annual Symposium in Pediatric Nephrology, Feb. 23-27, Miami. Contact: University of Miami, P.O. Box 016960, Miami 33101, (305) 549-6726.

Update on Surgery and Management of Colorectal Diseases, Feb. 24-26, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neurology Update, Feb. 25-March 2, Sheraton Bal Harbour, Bal Harbour. Contact: University of Miami, Division of CME D23-3, P.O. Box 016960, Miami 33101, (305) 547-6716.

Eighteenth Teaching Conference in Clinical Cardiolgy, Feb. 26-March 1, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., D-41, P.O. Box 016960, Miami 33101, (305)547-6491.

Health Care of the Elderly, Feb. 27-March 1, USF College of Medicine, Tampa. Contact: Eric Pfeiffer, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-4355.

Current Concepts in Surgery of the Gastrointestinal Tract, Feb. 27-March 1, Diplomat Hotel, Hollywood. Contact: University of Rochester, 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Surgical Anatomy of the Eyelids, Orbit and Lacrimal Apparatus, Feb. 27-March 1, Lincoln Hotel and USF College of Medicine, Tampa. For more info: Jay J. Older, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-3170.

MARCH

Difficult Questions for Pulmonary Medicine, March 1, The Rusty Pelican, Tampa. Contact: David A. Solomon, M.D., 13000 N. 30th Street (111C), Tampa 33612, (813) 972-2000.

Internal Medicine 1986, March 2-7, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bodes, M.D., P.O. Box 016760, Miami 33101, (305) 547-6063.

Internal Medicine Update, March 2-8, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Epidemiology and Prevention of Cardiovascular Disease, March 3-5, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neuroradiology: New Horizons and Current Concepts, March 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: Robert M. Quercer, M.D., P.O. Box 016960, Miami 33101, (305) 547-6716.

Neuroradiology: New Horizons and Current Concepts of Classic Issues, March 3-7, Sheraton Bal Harbour, Miami. Contact: Joyce E. Freeman, P.O. Box 016960, Miami, FL 33101 (305) 549-6894.

Florida Society of Ophthalmology Annual Meeting, March 6-8, Palace Hotel, Lake Buena Vista. For more info: Florida Society of Ophthalmology, 1133 W. Morse Boulevard, #201, Winter Park 32789, (305) 647-8839.

Ophthalmology Talks, March 7-8, Palace Hotel, Lake Buena Vista. Contact: Avery Weiss, M.D., (813) 974-3170.

Twenty-First Annual Meeting of the American Society of Contemporary Medicine and Surgery, March 9-13, Diplomat Hotel, Hollywood. Contact: John G. Bellows, M.D., 211 E. Chicago Ave., Sute 1044, Chicago, IL 60611, (312) 787-3335.

Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. Contact: Bernard Germain, M.D., USF College of Medicine, Box 19, Tampa 33612.

Breast Disease Update III, March 12-16, Hilton Hotel, Lake Buena Vista. Contact: Noel Zusmer, M.D., 4300 Alton Road, Miami Beach, FL 33140, (305) 674-2418.

Pediatric Urology; for the Urologist, March 14-16, Doral Beach Hotel, Miami Beach. For more info: American Medical International, 6614 Miami Lakes Dr. East, Miami Lakes 33014, (305) 687-1367.

Pediatric Intensive Care, March 17-19, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Eighth Annual Family Practice Review, March 17-21, Adam's Mark Caribbean Gulf Resort, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 6th Street South, St. Petersburg, FL 33701, (813) 893-6156.

Infectious Disease and Antibiotic Therapy, March 18-22, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Contemporary Hepatology, March 20, USF, Tampa. Call: William Boyd, M.D., (813) 972-2000.

Seventeenth Annual Topics in Internal Medicine, March 20-22, Gainesville Hotel, Gainesville. Contact: A. Jay Block, M.D., JHMHC J-233, Gainesville 32610, (904) 392-3143.

Issues in Perinatal Care 1986, March 21-22, Halifax Hospital, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Boulevard, Daytona Beach. (904) 252-4701.

Vascular and Pulmonary Diseases: Diagnosis and Managment, March 21-23, Bahia Mar Hotel, Ft. Lauderdale. Call: Stephen E. Mattingly, (303) 798-9682.

Advances in Diagnostic Imaging, March 22-30, Switzerlan, St. Moritz. Contact: Lawrence Muroff, M.D., (813) 974-7267.

1986 Update on Diseases and Imaging, March 31-April 2, Walt Disney World Village Hotel, Lake Buena Vista. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813)974-2538.

APRIL

Critical Care Medicine, April 1-5, Hotel Royal Plaza, Lake Buena Vista. Call: Alan Varraux, (305) 841-5144.

Radiology of Hepatobiliary and Pancreatic Disease: Imaging and Intervention, April 1-5, Miami Hyatt Regency, Miami. Contact: Jill Nolden, Division of Diagnostic Radiology, P.O. Box 016960, Miami, 33101, (305) 549-6894.

Fourth Annual Interventional Radiology Seminar, April 2-5, Palace Hotel, Lake Buena Vista. Contact: Martin Selbiger, M.D., (813) 974-2538.

Regional Cancer Conference, April 8-11, Lake Buena Vista, Lake Buena Vista. Call: Clarence Brown, M.D., (305) 841-5144.

Forty-First Regional Family Practice Weekend, April 11-13, Lincoln Hotel, Tampa. Contact: Robert L. Dawson, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

1986 Radiation Therapy Seminar, April 17-19, University Centre Hotel, Gainesville. Contact: Division of Radiation Therapy, JHMHC J-385, Gainesville, 32610.

Clinical Virology Seminars, April 21-23, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-2178.

Physiology of Fitness, April 22-26, Sonesta Village Hotel, Orlando. For more info: Alan Varraux, M.D., (305) 841-5144.

MAY

Five-Day Diabetes Management Course, May 12-16, USF College of Medicine, Tampa. Call: Anthony Morrison, (813) 974-4360.

ONGOING

Seminars — Most major ski areas, Club Med, Disney World and other resorts. Topic: Medical/Legal and Financial Management. Accredited. Current Concept Seminars, Inc. (since 1980) 3301 Johnson St., Hollywood, FL 33021 (800) 428-6069. Fee $175.



PREGNANT MOTHERS: PLEASE DON'T SMOKE!

Here are three good reasons to quit smoking now:

1 Smoking retards the growth of your baby.

2 Smoking increases infant mortality.

3 Your family needs a healthy mother.

Don't smoke.
For your baby's sake.
And yours.

AMERICAN CANCER SOCIETY

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

GENERAL INTERNISTS, PEDIATRICIANS, NEUROLOGISTS, ENT, THORACIC AND GENERAL SURGERY, DERMATOLOGY, FAMILY PRACTICE, HEMATOLOGY/ONCOLOGY: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

PHYSICIAN WANTED: Orthopaedic Surgeon, young, ambitious M.D. wanted to share general orthopaedic practice with two established practitioners in the Ft. Walton Beach area. Must have excellent references. Contact William R. Marshall, M., PA and Thomas A. Dlabal, M.D., 928-D Mar Walt Drive, Ft. Walton Beach, Fl 32548.

ESTABLISHED, BOARD CERTIFIED, F.A.C.O.G. seeks female or male board certified/board eligible to join in practice locating in central Florida. Attractive first year salary, leading to full partnership, fringe benefits. Send curriculum vitae to: Post Office Box 392, Lakeland, Fl. 33802.

SOUTH FLORIDA FAMILY PRACTICE — Very busy two-man practice, fully-equipped, new ambulatory center, rapidly expanding. Need young, bright, energetic and empathetic physician with view to full partnership. Excellent salary, benefits, insurance, etc. Florida license required. Send curriculum vitae to: Sunshine Medical Center, 6341 Sunset Drive, South Miami, Florida 33143. All inquiries strictly confidential.

DIAGNOSTIC RADIOLOGIST — Wanted to join hospital and office practice in growing central Florida area serving population of approximatly 50,000. Must be trained in all modalities. Send CV to R.I.A., P.O. Box 3477, Sebring, FL 33870, or call Dr. Lovelace (813) 385-6101, Ext. 253.

DAYTONA BEACH — Board Certified or eligible general medical internists/family practitioners needed to staff new Veterans Administration Outpatient Clinic. Ideal working conditions and hours — 8:00 a.m.-4:30 p.m. Monday through Friday. Competitive salary and liberal fringe benefit package. Send CV to Josh Davis, M.D., Chief Medical Officer, VA Outpatient Clinic, 1900 Mason Avenue, Daytona Beach, FL 32017. EO Employer.

OB-GYN eligible or Board Certified physician to join the medical staff of the University of South Florida Student Health Service on a full-time basis. Practice limited to Gynecology. Florida license required. Recruiting deadline: 1/10/86. Contact Maria J. Anderson, M.D., Director, University of South Florida Student Health Service, 4202 E. Fowler Avenue, CTR 312, Tampa, Florida 33620. Phone (813) 974-2331. Affirmative Action Equal Opportunity Employer.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

PEDIATRICIAN: 32 physician, multi-specialty group practice accepting applications for a full time, energetic pediatrician. Send CV to: Administrator, Suncoast Medical Clinic, 700 Sixth Street South, St. Petersburg, FL 33701.

FLORIDA MEDICAL DIRECTOR: Full-time salaried position directing a staff consisting of thirty-one (31) full-time physician employees. 180 bed acute care facility, not for profit, located in Bartow, Florida, approximately equal distance from Tampa and Orlando, near Winter Haven and Lakeland. Must be licensed in Florida with a minimum of five (5) years leadership/management experience. Board certified in at least one specialty. Position reports to the Board of Trustees through the Hospital Administrator. Interested parties should send CV to: Hospital Administrator, Polk General Hospital, P.O. Box 816, Bartow, FL 33830.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

EMERGENCY PHYSICIAN needed for independant group at new Gulf-coast hospital. Expected income over $100,000. Send CV to C-1285, P.O. Box 2411, Jacksonville, Fl. 32203.

WANTED: INVESTING and participating M.D. for walk-in medical center, Orlando area. Call after hours — (813) 646-6612.

FT. LAUDERDALE, Jacksonville, Daytona Beach and Tallahassee — Experienced Emergency Physicians needed. Enjoy flexible scheduling as an Independent Contractor. Yearly compensation ranging from $80,000 — $125,000. Contact: Kathy Valli, Coastal Emergency Services, Inc., 220 West Commercial Blvd., Ste. 203, Ft. Lauderdale, FL 33309 or call (800) 328-1038 in US or (800) 432-3093 in FL.

INTERNIST: Veterans Outpatient Clinic seeks a half-time or full-time Primary Care Internist. Excellent salary and working conditions. Send CV to Fred Wasserman, M.D., VA Outpatient Clinic, 2070 Carrell Road, Ft. Myers, Fl. 33901. An Equal Opportunity Employer.

ATTN: ALL MEDICAL SUBSPECIALTIES: Primary Care facility in West Palm area seeks association with all medical subspec. We will provide all overhead, including staff. We will share advertising expense. Send CV to Administrator, P.O. Box 16474, West Palm Beach, FL 33416.

PRIMARY CARE FACILITY in West Palm Beach seeking P/T physicians for hourly work and full time physicians for future facilities. Send CV to P.O. Box 16474, West Palm Beach, FL 33416.

EXCITING OPPORTUNITY for Florida, American Schooled, Licensed Internist, General Practioners, and/or Emergency Room Physicians on Florida's Treasure Coast. Send CV and references to Joemax Smith, Insta-Med Clinics, 1360 U.S. #1, Suite 6, Vero Beach, FL 32960.

ORLANDO — Family practice BE/BC career opportunity high quality, unique concept for FP's to meet challenge of medicine's change. Compensation guarantee, incentive with option to buy in. Must be ambitious, intense, and have impeccable credentials, Fla. license. Troy Overstreet, 120 Sunnytown Road, Casselberry, FL 32707, (305) 339-7171.

RADIOLOGIST for private outpatient clinic, Coastal Florida City. Approximately 15-20 hours per week. No weekends or nights. Ideal for retiring physician. Send reply to C-1308, Box 2411, Jacksonville, Fl. 32203.

EMERGENCY PHYSICIAN, U.S. Residency-trained and Board Certified by A.B.E.M. needed to five-man fee-for-service group in Sarasota. 800 bed full-service hospital. Immediate full status in group. Call S. Newman, M.D. at (813) 923-6317 or send CV to S. Newman, M.D., Memorial Hospital, 1700 S. Tamiami Trail, Sarasota, Florida 33579.

INTERNIST to work full time in busy medical center in West Boca Raton. Competitive salary. Please mail CV to: Medical Director — The Medical Center of West Boca Raton, 19801 Hampton Drive, Boca Raton, FL 33434, or call Tonia Reeves at 483-5100. Equal Opportunity Employer.

NEUROLOGIST, Board certified or eligible to join a solo practice in a rapidly growing community located in Florida sunbelt. Full EP, EMG, EEG and CT facilities. Plan to expand services. Early full partnership. Reply with CV to Box C-1294, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PHYSICIAN to join expanding family practice in Jacksonville. Excellent benefits and growth potential. Board certified or eligible preferred. Send CV to Stephen Clark, M.D., 4131 University Blvd. S., Jacksonville, FL 32216.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only. C-1289, P.O. Box 2411, Jacksonville, FL 32203

FAMILY, GENERAL OR INTERNAL medicine practitioner needed immediately for a well established, successful Family/General Practice in North Central Florida. Office has laboratory, x-ray, EKG facilities. Board Certified or eligible preferred but not necessary. Send CV to C-1307, P.O. Box 2411, Jacksonville, FL 32203.

Situations Wanted

LOCUM-TENENS: Radiologist, Board Certified, 53, academic and administrative experience, does most modalities, will also consider permanent association. Please write Box C-1265, P.O. Box 2411, Jacksonville, Fl. 32203.

PSYCHIATRIST, bd. certified, university trained, lic. Ohio, Indiana, Illinois (but not planning to sit for Fl license) seeks employment in Florida — in a position where Florida license would not be required. Available 1/1/86. Reply to Box C-1293, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST seek to purchase established medical practice in Florida. Reply C-1184, P.O. Box 2411, Jacksonville, FL 32203.

UROLOGIST, currently chief resident at Cleveland Clinic, looking to join solo, group, or multispecialty practice, Gulf or East Coast Florida. Well-trained in all aspects of Urology. Available July 1986. Send responses to Box C-1300, P.O. Box 2411, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST: University trained waith Fellowship in ultrasound-computed tomography and radiological imaging seeks group practice — hospital or solo. Reply C-1301, P.O. Box 2411, Jacksonville, Fl, 32203.

CARDIOLOGIST with 3 years of Fellowship training, university hospital invasive and noninvasive cardiology, Florida licensed, seeking practice opportunity. Available immediately. C-1304, P.O. Box 2411, Jacksonville, Florida 32203.

PULMONOLOGIST: Boarded in Internal Medicine and Pulmonary disease. Extensive hospital-based practice experience including I.C.U., outpatients, academics and quality assurance. Moved to Tampa to keep family together, and looking for parttime employment in Tampa area. Contact: John M. Moorhead, M.D., 5317 Northdale Blvd., Tampa, FL 33624.

FAMILY PRACTITIONER: Board Certified FAAFP, Florida licensed. Seeks position part to semi-full time. Interested in clinic or minor emergency medicine. Please send full details with first reply. Palm Beach County pereferred. Contact C-1302, P.O. Box 2411, Jacksonville, Fl. 32203.

INTERNIST completing sub-specialty fellowship in pulmonary medicine July 1, 1986 seeking academic and clinical practice group for affiliation. CV, recommendations, etc. on request. Please respond to Warren S. Goff, D.O., 21631 Jacksonville Road, Farmington Hills, Mi. 48027, phone 313-474-4414.

Practices Available

PEDIATRICS, N.E. COAST. Well established, fully equipped. Excellent community hospital (NICU & Pediatric Ward), charts, office, equipment, good will. Transferable. Easy terms. BE/BC. Contact C-1298, P.O. Box 2411, Jacksonville, FL 32203.

CENTRAL FLORIDA: General internal medicine practice for sale. Beautiful college town close to Daytona Beach and Orlando. Annual gross of $140,000 plus. Leaving for faculty position. Call (904) 738-0070.

EXCELLENT OPPORTUNITY FOR GP. I'm retiring after 48 years in Palatka. Need someone to take over busy practice. Call (904) 325-2053 Tuesday or Friday, ask for Mrs. Smith.

NORTH CENTRAL Florida. University and medical center community. Solo pediatric practice. Will phase out if desired. Excellent hospital nearby. C-1305, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

FOR RENT — Medical office suite in Vero Beach, FL; aproximately 3,000 square ft., excellent parking, attractive, sound brick building. Five year lease offered at $3,500 per month. Located on waterfront, 30 Royal Palm Blvd. — perfect for primary care physicians, family practice, or walk-in clinic. Call (305) 562-7922 and ask for Bruce MacIntyre. 701 Shore Dr., Vero Beach, FL 32963.

FOR RENT — JACKSONVILLE — Office space partially furnished in Dillon Building next to St. Vincents Hospital. 1265 sq. ft. now being used by two active physicians planning to relocate. Available January 1, 1986 or earlier. Call 904-388-2678.

HIGHLAND BEACH, Florida (near Boca Raton). East of Intracoastal. On island, deep canal dock, ocean access, walk to private beach. Low crime community. Four bedrooms/split. Built in 1982. Bette Conlon, (305) 391-9400.

SALE OF NEW AMBULATORY CLINIC, Jupiter (Indiantown Road). Rare opportunity available because of residency. 3,100 square feet, fully equipped, active center. Minimal cash required. (305) 586-3737 or 832-2400.

SHARE MEDICAL — surgical office 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441. 3 exam rooms, lab, and business office. Patrick E. Callaghan, M.D., (305) 428-2420.

PRIME MEDICAL OFFICE Space for rent. Reasonable, near new hospital. Zephyrhlls, FL. For information, please call (813) 782-4505.

MUST SELL: Beautiful condominium Palm Beach Area. Two baths, 2 bedrooms, pool, private beach, sun deck. Contact: Karen V. Marks, P.O. Box 2914, Winter Park, FL 32790.

FOR SALE: Ft. Lauderdale. House/medical office! Good area near Galleria on Bayview Drive. Spacious 2 bedroom home with 21' x 43' living room/family room and fireplace plus Doctor's office with reception area and 3 examining rooms. Large corner lot with good parking. Assumable 8.5% mortgage and owner will consider additional financing. Price reduced to $229,000 for quick sale! Call Guy or Jeanne Bass, Dutcher-Higginbotham & Bass, Inc., Realtors at (305) 525-2888 or 565-2883.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. 3 bedroom, 2 bath. Covered parking, pool, magnificent view St. John's River and downtown Jacksonville. Dock available. Below market. Phone (305) 278-1067.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Below market. Phone (305) 278-1063.

HIGHLAND BEACH, FL (near Boca Raton). East of intracoastal. Island living. Deep canal dock. Ocean access. Walk to beach. Low crime community. Ideal for boaters and ocean lovers. Four bedrooms, split. Built in 1982. Bette Conlon, 305-391-9400 or 305-421-7843.

Services

CHARTER M.D.'s 46 hatteras sportfisherman. Rupp Riggers, Penn International reels, latest electronics. Florida and the Bahamas. Contact Captain Reed (305) 283-4444, Stuart, Fl.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned Holter-Stress-Echo-EKG and other medical Electronic Instruments. Contact Ed Bentolila, P.O. Box 8676, Coral Springs, FL f33065, (305) 972-4600.

WANT TO RELOCATE? If so, we offer the simplest way to do it. We need all specialties. Send us you CV. We will condense it and will routinely circulate the condensed version to over 3,400 hospitals, clinics, group practices, and labs in 12 (AL, AR, FL, GA, KY, LA, MS, NC, OK, SC, TN, TX). All at no cost to you now or ever. Trent Associates, 2421 Shades Crest Road, Birmingham, AL 35216.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2 Box 386 A, Adel, Georgia 31620. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

Equipment

AVAILABLE FOR SALE: Raytheon Model RME-325R X-ray Generator, Raytheon Model TTS 471 Table Tubstand Combination, Machlett DX 42/40 X-ray Tube Unit, Machlett RBL-II Semi Automatic Collimator. Contact John Manry (305) 569-3771 for further information.

APPOINTMENT SCHEDULING Software for a small clinic, doctor's or dentist's office with IBM-PC or MS-DOS compatible microcomputer. Very easy to use. Computer background not necessary. Price: $245. Professional Technology Systems, P.O. Box 893, Jensen Beach, FL 33457.

Meetings

WEEKLY SEMINARS. Most major ski areas, Club Med, Disney World, Cruising aboard sailboats in the Virgin Islands or a Mississippi Paddlewheeler. Topic: Medical-Legal Issues., Accredited. Current Concept Seminars, Inc. (since 1980). 3301 Johnson St., Hollywood, FL 33021, (800) 428-6069. $175.

1986 CME CRUISE/CONFERENCES on selected medical topics: Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. Seven-twelve days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

BIOFEEDBACK THERAPIST TRAINING PROGRAM — Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training sit luxury beachfront hotel. CEU's Available. Jan. 17-19 and Jan. 24-26, or March 1-3 and March 15-17, or May 16-18 and May 30-June 1, or July 11-13 and July 25-27, 1986. For brochure contact: Hartje Stress Clinic, 2429 University Blvd. West., Jacksonville, Fl 32217. (904) 737-5821.

Index to Volume 72
January-December, 1985

Annual Meeting:
- First House of Delegates 593-8
- General Session 607-8
- Index to Proceedings 568-8
- President's Address 585-8
- Report of Reference Committee I 614-8
- Report of Reference Committee II 619-8
- Report of Reference Committee III 625-8
- Report of Reference Committee IV 666-8
- Report of Reference Committee V 678-8
- Second House of Delegates 612-8
- Third House of Delegates 660-8

Auxiliary Page:
- Allied Health Careers Recruitment 55-1
- A Time for the Doctor 127-2
- Encouraging Older Adults to Enjoy Life 879-10
- First Male Spouse in the Dade County Medical Auxiliary, The 1067-12
- How the Auxiliary Helps International Health Projects 991-11
- Marketing Membership 795-9
- Medical Malpractice — A Study in Evolutionary Politics 549-7
- Orange Jackets, The 717-8
- Parenting: Skills and Smiles 309-4
- Reflections of an Auxiliary Year 377-5
- Silent Crime, — Child Abuse, The 203-3
- We Care 461-6

Board of Governors:
- Summary of the FMA Board of Governor's Meeting, January 12, 1985 62a-2
- Summary of the FMA Board of Governor's Meeting, March 9, 1985 218a-4
- Summary of the FMA Board of Governor's Meeting, June 29, 1985 562a-8

Book Reviews 459-6; 545-7; 713-8; 793-9; 875-10; 989-11; 1063-12

Classified Advertisement 64-1; 134-2; 210-3; 316-4; 386-5; 470-6; 554-7; 724-8; 802-9; 886-10; 998-11; 1074-12

Correction 1061-12

Correspondence 122-2; 372-5; 456-6; 539-7

Dean's Message:
- A Revolution 52-1
- Brother Against Brother? 535-7
- Clapper and the Bowl, The 982-11
- Environmental Adaptation 865-10
- Erroneous Perception 192-3
- Green Stamps or Education 301-4
- Humanities in Medical Education, The 119-2
- In Vitro Fertilization and Embryo Transfer: New Horizon in Treatment of Infertility at the University of Miami School of Medicine 453-6
- Physician and Patient 787-9
- Preventive Medicine 704-8
- Tropical Medicine in Semi-Tropical Florida 368-5

Deaths 464-6

Editorials:
- A Contract Broken 749-9
- A Covenant for 1985 13-1
- Aging: Medicine's New Frontier 229-4
- American FMGs: A Growing Dilemma 915-11
- Battling the Ghosts of Yesteryears 827-10
- Cigarette Smoking on Trial 1022-12
- Corporate Medicare and the American Spirit 1023-12
- Cracks in the Image or What Patients Think Of Us 573-8
- Demedicalization of America, The 575-8
- Governor's Plan Addresses Health 414-6
- Health Care Consumer Protection and Awareness Act — A Challenge, The 161-3
- Investing In Our Future 87-2
- It's Time to Start 577-8
- Long Term Care: Problems Today and Tomorrow 917-11
- Malpractice Relief: Is It Coming? 491-7
- Medical Unions: the Potential and the Pitfalls 747-9
- Medicine Under the Gun 489-7
- Message of Christmas, The 1021-12
- New Rules, New Dilemmas 825-10
- On Parting 341-5
- Only Alternative, The 826-10
- Perez, Luis M., M.D. 409-6
- Physician in Literature, The 917-11
- Plague is Spreading, The 751-9
- Reflections On A New Season 412-6
- Remigio G. Lacsamana, M.D., New Editor of the *JFMA* 411-6
- Right to Health Care, The 13-1

Encores!:
- An Important Message For All Licensed Physicians 865-10
- Are Charges Too High? 454-6
- Confronting the Pied Pipers of Sex 455-6
- Considering a Medical Career 790-9
- Cost Effective or Quality Care: Which Shall it be? 1056-12
- Dealing With Conflicts of Interest 983-11
- Do We Have Any Choices 705-8
- Fee Splitting in the '80s? 868-10
- Health Policy in 1985 and Beyond 869-10
- How to Drive Nurses Crazy 789-9
- Liability Nightmare 788-9

Passive Smoking: Has the Threat Proved True? 535-7
Regulatory Boards are Working Better Than Ever..1057-12
Remember May at the FMA 710-8
Renaissance of Medical Humanism 704-8
Thoughts on the Medical Malpractice Reform Act of 1985 1059-12
Too Many of Us? 537-7
Utilization Controls and Quality of Care.....985-11
What Can Doctors Do When a Colleague Is Incompetent? 707-8
What Kind of Justice Is This? Save Us From the Lawyers 867-10
Will the Real Family Physician Please Stand Up 538-7

FMA Leadership Conference Summary, February 1-3, 1985 135-3

FMF Impaired Physicians Newsletter 2a-1; 234a-4; 478a-7; 814a-10

Letters and Viewpoints 579-8; 755-9; 831-10; 921-11; 1027-12

Medical Economics:
Academic Medical Center as an Endangered Species, The 1047-12
Health Maintenance Organization As a Cost Containment Instrument, The: Logic or Illusion ...527-7
Indigent Care: Salvage the System or Continue Its Carnage? 697-8
Inquisition of the Medicare Physician Reimbursement System.....781-9
Medical Care: A Tangled Web of Paradoxes 447-6
Pecuniary Benefits of Medical Care, The 857-10
Physician-Hospital Joint Ventures 975-11
Understanding the Challenge of Facing Teaching Hospitals 1048-12

Meetings 58-1; 130-2; 206-3; 314-4; 382-5; 468-6; 552-7; 720-8; 798-9; 882-10; 994-11; 1070-12

Notes and News:
AAFP Offers New Service to Help Family Doctors Find Practice Locations 451-6
"Alliance for Care" Conference to be Held 118-2
AMA Market Area Profile (MAP) Service, The 786-9
AMA-PSAs Promote Positive Aspects of Aging.....293-4
AMA Publishes Current List of Self-Designated Practice Specialties 452-6
AMA Offers a Workshop to Assist Physicians and Medical Office Staff in Maximization of Office Efficiency in Practice 1056-12
Arthritis Endowment by UF Graduate Lewis Schott Brings Major Boost to Arthritis Research 785-9
Connar, Richard G., M.D., Named USF Vice President for Medical Affairs.....451-6
Council on Hospital Medical Staffs Holds Its First Statewide Meeting 293-4
Dobbins, Burns A., Jr., M.D., 1915-1985.....367-5
Dr. Bolivar Honored Posthumously by French Government 52-1
Dr. Boyce elected Governor of the American College of Gastroenterology 118-2
Dr. Brown Honored by the Medical Association of the Bahamas 118-2
Dr. Feinstein Steps Down as Editor of *Miami Medicine* 703-8
Dr. Glass Named President-Elect of ACRM 982-11
Dr. Goetz Appointed Impaired Physicians Medical Director 117-2
Dr. Mahan Receives National Award for Preterm Birth Prevention 51-1
Dr. McKechnie Elected President of American Society of Anesthesiologists.....982-11
Dr. Prather Appointed State Epidemiologist 703-8
Dr. Saltz Elected to Fellowship in ACP 118-2
Dr. Schiebler to Fill New Leadership Role at UF's Health Science Center 451-6
"Eat Your Spinach" Can Be Terrible Advice For Sulfite-Sensitive Kids 533-7
Final Plans Coming Together for 111th Annual Meeting Scientific Program 191-3
FMA Committee on Impaired Physicians to Hold Workshop.....533-7
FMA Establishes Medical/Legal Hotline 534-7
FMA Receives Plaque for AMA Membership Increase 367-5
JCAH's Board Approves Revised "Rehabilitation Services" Chapter of 1986-AMH 863-10
JCAH Seeks Qualified Physicians As Surveyors 535-7
JFMA Featured in Medical Journalism.....293-4
National Eye Care Project Launched for the Elderly 1056-12
Netter, Frank H., M.D., Honored by Georgetown University 533-7
1986 Leadership Conference to Include House of Delegates Meeting 863-10
1986 Leadership Conference to Include Interim House of Delegates 981-11
111th Annual Meeting — Scientific Program Complete 293-4
Palm Beach County Chapter of Heart Association Funds New Schiebler Chair in Pediatric Cardiology 1055-12
Palm Beach County Medical Society EVP Dies.....52-1
Restaurant List for Dining During FMA Annual Meeting 299-4
Seminole County Department of Health and Human Services Dedicated 117-2
Suncoast Gerontology Center Receives $150,000 Grant 785-9
UF Faculty Accept Leadership Roles in State Anesthesiologists' Society 51-1
USF Researcher's Discovery Helps Identify Infant Disease 864-10
USF's Gerontology Center Initiates Seminar.....118-2
Watson, Robert T., M.D., Wins 1985 Hippocratic Award 368-5
Video Health Fair — A New Concept in Public Service by the Medical Profession 192-3
Workshop on Marketing Strategies for Private Practice 703-8

President's Page
Another Call for Unity 337-5
Board of Governors: An Open Forum 485-7
Business and Government: Roadblocks to Quality Care.....909-11
FMA Meeting the Legislative Challenge.....9-1
FMA Prepares to Address the Professional Liability Crisis in the 1985 Legislative Session.....155-3
FMA's Public Education Program 569-8
Graying of America, The.....225-4
Indigent Care — A Problem for all Citizens 821-10
Long Range Planning for the Florida Medical Association 83-2
Reflections on the Past Bring Goals for the Future.....1017-12
Tort Reform Through One Body/One Will 741-9
Working for Unity and a New Beginning.....403-6

Scam of the Month 53-1; 123-2; 199-3; 306-4; 372-5; 456-6; 541-7; 710-8; 791-9; 872-10; 986-11; 1061-12

Scientific Articles:

Aberrant Right Subclavian Artery as a Cause of Respiratory Distress and Dysphagia in an Adult 840-10
Cervical Dilitation in the Nonpregnant Patient With Vaginal 16-Dimethyl Prostaglandin E_2 426-6
Children's Medical Services: Florida's Expanded Crippled Children's Program from the 1920s to the 1980s 350-5
Computerized Tomography and Electroencephalography in Childhood Coma: Which Test Should be Performed First? 843-10
Contemporary Surgical Management for Hepatic Metastases of Colorectal Origin 91-2
Current Research Activities on Some Toxic Environmental Substances of Major Concern to Floridians 419-6
Experience with Routine Thyroid Function Testing: Abnormal Results in "Normal" Populations 835-10
Endorectal Irradiation — Conservative Therapy for Cure of Early Rectal Cancers 1038-12
Fatal Nonmetastatic Neurological Complications of Pulmonary Carcinoma 345-5
Fracture of Humerus From Muscular Violence: Case Report 103-2
Management of Diabetes in Pregnancy 170-3
Percutaneous Removal of Kidney Stones 167-3
Persistent Hypoglossal Artery in Ischemic Intracraniel Cerebral Vascular Disease, The 357-5
Presentation of Hemophilia A in the Newborn Period 99-2
Pseudocarcinoma: A Major Pitfall in the Practice of Hematology/Oncology 176-3
Risk Factor for Tumor Recurrence After Radical Hysterectomy for Stage IB Squamous Cancer of Cervix 768-9
Screening for Diabetes Mellitus 1033-12
Technetium 99m MDP Uptake in Drug-Induced Fibrous Myopathy 1042-12
Thin Needle Aspiration Biopsy as Diagnostic Tool: Community Hospital Experience 761-9
Tongue Metastasis From Undifferentiated Small Cell (Oat Cell) Lung Cancer 428-6
Toxic Environmental Substances and Concerns of Their Effects on Public Health 765-9

Special Articles:

Academic Radiology: Can It Survive 522-7
A Job Well Done 363-5
Cost of No Prenatal Care, The 852-10
Florida Patients' Compensation Fund and Florida Medical Malpractice Joint Underwriting Association, The 183-3
Florida Physicians' Insurance Reciprocal Rehabilitation Plan Successful 107-2
General Practice in Rural Florida: Case Study of an Anomaly 517-7
Health Maintenance Organizations and the Medicare Program 777-9
Hospice Model, The 438-6
Hospital Medical Staffs: the Future is Now 773-9
Medicine Obeys the Law: Part II 435-6
One Doctor's View of the FMA Annual Meeting 440-6
Prehistoric Syphilis in Florida 109-2
Present Status of Scoliosis Screening in Florida Schools 847-10

Special Issues:

Auxiliary Special Issue on Aging:

Aging Skin, The 245-4
Alzheimer's Disease — A Team Approach to Diagnosis and Treatment 255-4
Anxiety, Depression and Health Locus of Control Orientation in an Out-Patient Elderly Population 281-4
Auxiliary Special Issue on Aging 235-4
Caregivers of the Demented Elderly 266-4
Community Care for the Elderly 238-4
Involuntary Guardianship: Panacea or Bitter Pill 276-4
Lifelong Learning: Prescription for Health 252-4
Megatrends in Volunteerilng for and by the Aging 263-4
On Death and Dying 271-4
Population Aging as Progress not as Burden 241-4
Program of Health Education for People 55 and Better 249-4
Remarks from Mrs. Adele Graham 236-4
Role of Acute Care Hospital in Long-Term Care — a Model Program on South Miami Beach 258-4
What Florida's Elderly Need from the Medical Community 274-4

Special Issue on Cancer:

Breast Self Examination: A Patient-Physician Partnership 29-1
Childhood Cancer — Early Detection and Prevention 45-1
Colorectal Cancer 32-1
Early Detection of Uterine Cancer 36-1
Lung Cancer — The Case for Prevention 22-1
Make Early Cancer Detection a Health Habit — Adopt a Low Cancer Lifestyle 19-1
Nutrition and Cancer: Recommendations of the American Cancer Society 25-1
Teaching Patients about Testicular Cancer 41-1
We Can Prevent Cancer 20-1

Special Issue on Child Abuse:

Abuse of Infants by Manual Shaking, The: Medical, Social and Legal Issues 503-7
Child Abuse by Burning 497-7
Child Abuse: Old Problem, New Perspectives 495-7
Incestuous Family, The: Profile and Treatment Plan .508-7
Spasmus Nutans Occurring With Child Abuse/Neglect 511-7

Special Issue on Health Care for Women In Florida:

Diagnostic and Therapeutic Advances in Reproductive Endocrinology and Infertility 954-11
Foreward 927-11
Freestanding Birthing Facilities and their Impact on the Future of Health Care 942-11
Greetings from Paula Hawkins 929-11
Gynecologic Oncology — Regional Referral Centers 959-11
Malpractice Crisis as Related to Obstetrician/ Gynecologists in Florida 967-11
Our Aging Female Population: A Preventive Approach to their Health Care 962-11
Perinatal Care Problems in an Indigent Population: Hillsborough County 945-11
Perinatal Care Problems of the Indigent Population in Miami 939-11
Preface 931-11
Role of Florida Section, ACOG, in Health Care of Women in Florida 950-11

Role of Obstetrician/Gynecologists in Breast Disease: An Approach 933-11
Upgrading Care for Indigent Women in Florida: Role of Department of Health and Rehabilitative Services 935-11
Women's Medical Centers of Florida 970-11

Worth Repeating:

ADAMHA Stressing Prevention Studies 194-3
Alternative Care Systems: A Commentary 369-5
Employing the Older Worker 302-4
Medical Care in Changing Economic Environment ... 119-2

Authors

Aballi, Arturo J., Miami 843-10
Adams, David P., Gainesville 517-7
Ajmone-Marsan, Cosimo, Miami 843-10
Alfonso, Israel, Hialeah 843-10
Arnone, James J., Riviera Beach 508-7
Arroyo, Jorge G., Tampa 761-9
Atkeson, Thomas D., Tallahassee 419-6
Ausbon, W.W., Gainesville 350-5
Averette, Hervy, Miami 959-11
Baird, Tim, Jacksonville 426-6
Banovac, Kresimir, Miami 835-10
Bean, William J., Jupiter 167-3; 357-5; 1042-12
Belles, Dale R., Gainesville 266-4
Benrubi, Guy, Jacksonville 426-6; 768-9
Bentley, James D. 1052-12
Bland, Kirby I., Gainesville 91-2
Borychow, Irwin B., Miami Beach 840-10
Bouis, Pierre J., Tampa 87-2
Brizel, Herbert E., Miami 1038-12
Brooks Jr., William G., Orlando 503-7
Buchdolt, Stephen L., Tampa 345-5
Caldwell, Jacques R., Daytona Beach 447-6; 527-7; 697-8; 781-9; 857-10; 975-11; 1048-12
Caram, Ivette, Missouri 843-10
Caranasos, George J., Gainesville 266-4
Cavanagh, Dennis, Tampa 36-1; 959-11
Chahirian, A. Philippe, New York 428-6
Chapunoff, Eduardo, Miami Beach 840-10
Cohen, Donna 302-4
Coleman, Frank C., Tampa .9-1; 83-2; 107-2; 155-3; 225-4; 337-5;
Coles, Robert, Cambridge, MA 917-11
Collins, Clyde M., Jacksonville 271-4; 31-1; 1021-12
Conlin, Mary M., Gainesville 281-4
Conn, James K., Tallahassee 161-3; 917-11; 985-11
Cotton, Shirley, Jacksonville 255-4
Cummings, K. Michael, Buffalo, NY 41-1
Cupoli, J. Michael, Tampa 497-7
Curless, Richard G., ... 843-10
Dabby, Emily (Mrs. Victor), Dade County 203-3
Daniel, Thomas M., Clearwater 773-9
Daughtry, James D., Jupiter 167-3
Davidson, Oscar, Miami 453-6
Davies, John E., Miami 419-6; 765-9
Davis, J. Mostyn 537-7
Deal, William B., Gainesville 52-1; 301-4; 535-7; 865-10
DeVita, Vincent T., Bethesda, MD 20-1
DeVito, Carolee A., Miami 258-4
Diebel, N. Donald, Orlando 852-10
Dockery, M.D., J. Lee, Gainesville 927-11
Eagan, Barbara A., Orlando 503-7
Eisdorfer, Cari, Bronx, NY 302-4
Elgin, Virginia Lukens, Largo 252-4
Essex, Virginia, Alexandria, VA 263-4
Faber, Aurohm, New Smyrna Beach 705-8
Farmer Jr., Frank H., New Smyrna Beach 575-8; 749-9; 827-10; 1023-12
Fayos, Juan V., Miami 522-7
Feinstein, Richard J., Miami 491-7; 865-10; 1057-12
Fennell, Eileen B., Gainesville 266-4; 281-4
Fischer, Lee A., West Palm Beach 13-1; 440-6; 777-9; 538-7
Flynn, Joseph C., Orlando 847-10
Fogel, Bernard J., Miami 192-3; 453-6
Gagan, Richard J., Tampa 497-7
Geiger, Eric F., M.D., Pensacola 950-11
Graham, Adele 236-4
Graham-Pole, John, Gainesville 99-2
Greenfield, Melvin C., Miami 1067-12
Hanson, Clayton V., Venice 249-4
Harrell, Henry L., Jr., Ocala 414-6; 454-6; 577-8
Hawkins, Paula 929-11
Hazlett, William, Jacksonville 768-9
Heverin, Edward, Daytona 975-11
Holleb, Arthur I., New York, NY 25-1
Holzman, Bernard H. 843-10
Hooper, Glenn S., Tampa 868-10
Horn, Carole, Washington, D.C. 707-8
Howard, William M., Gainesville 183-3
Howington, F. Lee, Ft. Meyers 931-11
Hung, Tran T., Miami 453-6; 954-11
Hyland, Dale J., Pinellas Park 276-4
Ingram, James M., Tampa 962-11
Iscan, M. Yasar, Boca Raton 109-2
Keller, Thelma L., Orlando 847-10
Kirkley, William H., Ft. Lauderdale 967-11
Kitchens, Craig S., Gainesville 176-3
Knapp, Richard M 1052-12
Knight, Jerry 867-10
Knuppel, Robert A., Tampa 945-11
Krischer, Jeffrey P., Gainesville 266-4
Kutz, Frederick W., Washington, D.C. 419-6
Lacsamana, R.G., Daytona Beach 412-6; 489-7; 573-8; 747-9; 751-9; 825-10; 915-11; 1022-12
Lake, Marian, Tampa 945-11
Laude, Isabella, Babson Park 127-2; 309-4; 717-8; 991-11
Lefall, LaSalle D., Washington, D.C. 32-1
LeMaire, William, Miami 453-6; 954-11
Leviton, Lawrence R., Riviera Beach 508-7
Lopez, Perez F., Miami 843-10
Luft, Harold S., San Francisco, CA 119-2
Macdonald, Donald Ian, Clearwater 194-3
Mahan, Charles S., Gainesville 935-11
Mandell, Harvey N. 789-9
Malone, John I., Tampa 1033-2
Mark, Alexandra, Boston, MA 455-6
Mark, Vernon H., Boston, MA 455-6
Mehta, Paulette, Gainesville 99-2
Miller-Shaivitz, Patricia, Boca Raton 109-2
Morgan, Linda, Gainesville 959-11
Moorer Jr., Samuel H., Tallahassee 511-7
Morales, Walter J., Orlando 852-10
Morris, Peter W., Birmingham, AL 369-5
Morrison, Anthony D., Tampa 1033-12
Mullin, David, Jupiter 1042-12
Murphy, Gerald P. 41-1
Murray, Louis C., Orlando 409-6
McFarland, Kay F., Columbia, SC 170-3
McKenzie, J. Maxwell, Miami 835-10
McLeod, Allan G.W., Miami 942-11
Nixon, D.G., Tampa 945-11
Notelovitz, Morris, Gainesville 962-11
Nunn, Daniel B., Jacksonville 341-5
Nuss, Robert C., Jacksonville 426-6; 768-9

Oppenheim, Mike, Los Angeles, CA 535-7
Osborne, Dennis R.S., Durham, NC 357-5
O'Sullivan, Mary Jo, Miami 939-11
Palmer, Barbara M., Tallahassee 238-4
Peddy, Robert B., Lakeland 710-8
Pedrero Jr., Edward, Tampa 826-10; 704-8
Perez, Luis M., Sanford 403-6; 485-7; 569-8; 741-9; 821-10 909-11; 1017-12
Pfaffenberger, Carl D., Miami 419-6; 765-9
Pfeiffer, Eric, Tampa 229-4
Pollack, Sheldon V., Durham, NC 245-4
Price, Charles T., Orlando 847-10
Prockop, Leon D., Tampa 345-5
Radar, David L, Jacksonville 107-2
Relman, Arnold S. 983-11
Riddick, Max R., Winter Park 847-10
Riggall, Frank C. 954-11
Roberts, William S., Tampa 36-1
Rodan, Bruce A., Jupiter 167-3; 357-5; 1042-12
Roper, William Z. 869-10
Rosenbloom, Arlan L., Gainesville 1033-12
Rosenfeld, Louis, Nashville, TN 790-9
Scheinberg, Labe 302-4
Schiff, Leon, Miami 787-9
Schulkind, Martin L., Gainesville 350-5
Schwartz, Ira S., NY 428-6
Scupholme, Anne 942-11
Seligson, Robert W., Jacksonville 773-9
Sheppard, Harold L., Tampa 241-4
Shockett, Everett, Miami Beach 29-1
Skylar, Jay S., Miami 1033-2
Smith, Fred O., Dunedin 435-6
Smith, Mrs. Laurin G. 377-5
Sodeman, William A., Tampa 119-2; 368-5; 704-8; 982-11
Soffer, Alfred, Park Ridge, IL 1056-12
Spore, Carolyn C., Deland 549-7
Sprenger, Thomas R., Bradenton 103-2
Sridhar, Kasi S., Miami 428-6
Stenger, Vincent G., Sarasota 931-11; 970-11
Straight, William M., Coral Gables 1063-12
Stump, Charles, Daytona Beach 933-11
Swing, Ann, Charlotte Harbor 274-4
Tate Jr., Charles F., Miami 22-1
Taylor III, Frank M., Tampa 761-9
Tepperman, Barry S., Hollywood 1038-12
Thames, T. Byron, Orlando 363-5
Thompson, Robert J., Jacksonville 426-6
Tignor, Jo, North Palm Beach 416-6
Van Eldik, Carol, Palm Beach County 879-10
Vaughn, Betty J., Orlando 852-10
Verkauf, Barry S. 954-11
Vizzo, Margaret (Mrs. Ferdinando), Tampa 55-1
Warson, Samuel R., Sarasota 438-6
Watkins, Alison H., Tampa 497-7
Westmark, Edwrad R., Pensacola 1059-12
Whelan-Williams, Susan, Orlando 503-7
White, James G., Daytona Beach 411-6
White, L.G., Ft. Lauderdale 235-4
Whittaker, David S., Ocala 795-9
Whitworth, J.M., Gainesville 495-7
Wilkinson Jr., Albert H., Jacksonville 45-1
Wodehouse, Sharon, Jacksonville 255-4
Yonker, Phyllis Goldner, St. Petersburg 99-2
Zakarija, Margita, Miami 835-10
Zavertnik, Joseph J., Miami 19-1
Zubkoff, William, Miami 258-4

ADVERTISERS

Ayerst Laboratories
Inderide LA 1064a

Biofeedback Institute
Course 1054

Brown Pharmaceutical
Android 1018
Lipo-Nicin 1053

Curtis 1000 Information Systems
Computers 1045

Eli Lilly & Company
Ceclor 1026a

Florida Hospital Medical Center
Meeting 1046

Florida Physicians' Insurance Reciprocal
Service 1010

Future Information Systems
Service 1031

GTE Telenet
Service 1016

Info Systems
Computers 1018

Knoll Pharmaceutical Company
Isoptin 1026b

Lake Butler Hospital Hand Surgery Center
Service 1054

Marion Laboratories, Inc.
Cardizem 1010a

National Rehabilitation Centers, Inc.
Recruitment 1062

New England Life
Service 1026

Parkway Regional Medical Center
Service 1025

Roche Products, Inc.
Dalmane 1083

Southeastern Medical Data Systems
Service 1011

University of Alabama
Service 1012

University of Miami
Meeting 1017

University of South Florida
Seminar 1053

Willingway Hospital
Service 1046

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

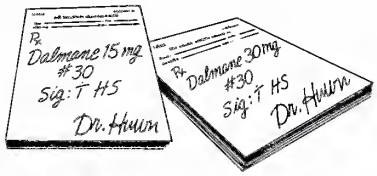
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓝ
sleep that satisfies

15-mg/30-mg capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. 3. Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. 4. Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. 8. Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
flurazepam HCl/Roche Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE®
flurazepam HCl/Roche ℞
sleep that satisfies



7 C01170 000
COLUMBIA UNIVERSITY
HEALTH SCIENCES LIBRARY
701 WEST 168TH STREET
NEW YORK, NY 10032

ROCHE®

Copyright © 1985 by Roche Products Inc. All rights reserved.

ل